

DLHS -2

A & N Islands (Union Territory)

Reproductive and Child Health

District Level Household Survey
2002-04



International Institute for
Population Sciences,
(Deemed University)
Mumbai – 400 088



Ministry of Health & Family
Welfare, Government of India,
New Delhi – 110 011



Population Research Centre,
Visakhapatnam – 530 003.

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KEY INDICATORS, ANDAMAN AND NICOBAR ISLANDS

DISTRICT LEVEL HOUSEHOLD SURVEY- REPRODUCTIVE AND CHILD HEALTH, (DLHS-RCH), 2002-04

Sample size			
Households surveyed.....	2,175		
Currently married women age 15-44.....	1,782		
Husbands of eligible women.....	1,140		
Characteristics of households			
Percent rural.....	67.0		
Percent Hindu.....	67.3		
Percent Muslim.....	9.6		
Percent other religion (Christian).....	22.1		
Percent scheduled caste.....	9.1		
Percent scheduled tribe.....	8.3		
Percent with electricity.....	87.2		
Percent with flush toilet.....	59.1		
Percent with no toilet facility.....	30.4		
Percent living in <i>Kachcha</i> houses.....	27.2		
Percent living in <i>Pucca</i> houses.....	50.7		
Percent with low standard of living.....	19.0		
Percent with high standard of living.....	50.5		
Percent with iodized salt (15+ppm).....	95.1		
Characteristics of currently married women age 15-44 years			
Percent below age 30.....	49.3		
Percent with age at first cohabitation below age 18.....	26.1		
Percent illiterate.....	22.0		
Percent having 10 or more years of schooling.....	29.4		
Percent with illiterate husbands.....	15.1		
Percent with husbands with 10+ years of schooling.....	37.8		
Marriage			
Mean age at marriage for boys.....	25.9		
Mean age at marriage for girls.....	21.4		
Percent of boys married below age 21.....	3.5		
Percent of girls married below age 18.....	3.6		
Fertility			
Mean children ever born to women age 40-44 years.....	2.8		
Percent of births of order 3 and above ¹	21.0		
Current use of family planning methods			
Any method.....	58.1		
Any modern method.....	57.3		
Pill.....	3.5		
IUD.....	3.8		
Condom.....	4.1		
Female sterilization.....	44.7		
Male sterilization.....	1.1		
Any traditional method.....	0.7		
Rhythm/safe period.....	0.5		
Withdrawal.....	0.1		
Unmet need for family planning			
Percent with unmet need for spacing.....	11.2		
Percent with unmet need for limiting.....	14.9		
Percent with total unmet need.....	26.0		
Maternal care²			
Percent of women received antenatal check-ups....	97.0		
Antenatal check-ups only at home.....	0.9		
Antenatal check-ups in first trimester.....	46.5		
Three or more visits for ANC.....	93.6		
Two or more tetanus toxoid injections.....	86.8		
Adequate Iron folic acid tablets/syrup ³	84.1		
Full antenatal check-ups ⁴	77.8		
Delivery characteristics²			
Delivery at home.....	24.5		
Delivery at government health institutions.....	70.5		
Delivery at private health institutions.....	5.0		
Delivery attendant by skilled persons ⁵	77.9		
Child health			
Percent of children whose mothers squeezed out milk from their breast ⁶	31.1		
Percent of children ⁷ with diarrhoea ⁸ who received ORS.....	81.7		
Percent of children ⁷ with pneumonia ⁸ who were taken to a health facility or provider.....	91.2		
Percent of children who received vaccinations⁹			
BCG.....	98.0		
DPT (3 injections).....	85.6		
Polio (3 doses).....	75.7		
Measles.....	85.7		
All vaccinations ¹⁰	69.3		
No vaccination at all.....	1.2		
Percentage of women who had			
Pregnancy complications ²	14.5		
Delivery complications ²	12.0		
Post delivery complications ²	7.4		
Symptoms of RTI/STI.....	5.8		
Problems of vaginal discharge.....	3.0		
Menstruation related problems.....	6.1		
Awareness of RTI/STI and HIV/AIDS			
Percent of women who have heard of RTI/STI.....	15.3		
Percent of women who have heard of HIV/AIDS.....	71.7		
Utilization of government health services			
Antenatal care.....	94.2		
Treatment for pregnancy complications.....	93.1		
Treatment for post-delivery complications.....	92.9		
Treatment for vaginal discharge.....	88.9		
Treatment for children with diarrhoea.....	96.2		
Treatment for children with pneumonia.....	94.6		
Quality of family planning services			
Percent non-users ever advised to adopt the family planning methods.....	43.9		
Percent users told about side effects of methods.....	50.6		
Percent users who received follow-up services.....	18.6		
Characteristics of husbands of eligible women			
Percent of husbands knowing NSV.....	10.3		
Percent of men who have heard of RTI/STI.....	53.0		
Percent of men who have heard of HIV/AIDS.....	77.7		
Percentage who had any symptoms of RTI/STI.....	4.7		
Sought treatment for RTI/STI.....	60.7		

¹ For births in past three years, ² For live/still births during three years preceding the survey, ³ 100 or more IFA tablets/Syrup, ⁴ A minimum of three visits for ANC, at least one TT injection and 100 or more IFA tablets/syrup, ⁵ Either institutional delivery or home delivery assisted by Doctor/ANM/nurse, ⁶ Last living child below age 3 years, ⁷ Children age below 3 years, ⁸ Last two weeks preceding the survey, ⁹ Last and least but one living children (age 12-23 months) born during three years preceding the survey. ¹⁰ BCG, three injections of DPT, three drops of polio and measles, vaccines.

PREFACE AND ACKNOWLEDGEMENT

Government of India had launched the Reproductive and Child Health (RCH) program to ensure that couples have access to adequate information and services for reproductive health care. As a first step, family planning targets have been withdrawn and an effort is being made to provide a package of reproductive services at different levels of health care centres.

Monitoring of the services is also being improved. New indicators are being added to assess quality of services and provision of an integrated reproductive health care services. The District Level Household Survey (DLHS) was initiated by Government of India and financed by the World Bank covering all the districts in the country. For the second time, district level estimates will be available for most of the critical reproductive health indicators. These important initiatives are certainly quite satisfying for all those who are concerned with taking ICPD reproductive health agenda ahead. The project is being coordinated by International Institute for Population Sciences, Mumbai and implemented by a number of consulting agencies.

For the purpose of data collection, uniform questionnaires, sampling design and field procedures were used throughout the country. The survey, thus, provided comparable data for all the districts in the state. The present report provides salient findings of Andhra Pradesh and covered all the districts. The findings of selected indicators of reproductive and child health services from the state of Andhra Pradesh are presented in the report.

It is believed that the data generated through the survey will meet the requirements of the Programme Administrators and Policy Makers for making effective interventions for providing quality services and achieving multiple objectives.

The DLHS-RCH could not have been successfully completed without cooperation and support from innumerable sources at various stages of the project. Although, it is not possible to acknowledge everyone involved in the survey, several organizations and individuals deserve special mention.

We would like to take this opportunity to acknowledge Shri P.K. Hota, Secretary, Ministry of Health and Family Welfare (MoHFW), Government of India. Our special thanks are due to Shri Y.N.Chaturvedi, Shri A.R. Nanda and Shri J.V.R Prasada Rao, former Secretaries, Department of Family Welfare, GoI, who gave us an opportunity to participate as consulting organization in the survey of the national importance. Our special thanks are due to Shri S.K. Sinha, Additional Director General, Ministry of Health and Family Welfare, GoI. Thanks are also due to Dr.K.V. Rao, Shri S.K.Das and Shri D.K. Joshi, former Chief Directors for their help. We are also thankful to Shri Partha Chattopadhyaya, Chief Director and Mr. K. D. Maiti, Director, Mrs. Rashmi Verma, Deputy Director and Mr.Rezimohn, Assistant Director, Statistics Division of MoHFW for all the support extended by them. Our special thanks are due to Dr. T.K. Roy, former Director and Senior Professor, IIPS, Mumbai for his timely advice and valuable guidance. Thanks are also due to Dr. G. Ramarao, Officiating Director, IIPS, Mumbai. We also acknowledge the contribution of Dr.F.Ram, Dr.B.Paswan, Dr.L.Ladu Singh, Coordinators of the

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We would be failing in our duty if we do not thank our respondents who spent their valuable time with tremendous patience.

Dr.M.Prasada Rao
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Visakhapatnam.

March, 2007.

SALIENT FINDINGS

For the assessment of district level Reproductive and Child Health indicators, Government of India proposed to undertake district level household surveys through non-governmental agencies on an annual basis. The District Level Household Survey (DLHS) was the result of government's initiative. In Andaman & Nicobar Islands, Population Research Centre, Visakhapatnam was entrusted the work of carrying out the survey. The survey for Phase-1 of the DLHS covering 1 district of the Union Territory was conducted during May 2003. The survey for Phase-2 covering the remaining district of the UT was carried out during November 2004. The focus of the survey was on: i) Coverage on ante-natal care (ANC) and immunization services, ii) Extent of safe deliveries, iii) Contraceptive prevalence rate and unmet need for family planning, iv) Awareness about RTI/STI and HIV/AIDS and v) Utilization of government health services and users' satisfaction. The salient findings of the survey are presented here.

For both the phases together, the data was collected from 2,175 households in Andamans & Nicobar Islands. From these households, 1,782 eligible women (usual residents or visitors who stayed in the sample households the night before the interview, currently married aged 15-44 years whose marriages were consummated) and 1,140 husbands of eligible women were interviewed.

Of the total households interviewed in Andamans & Nicobar Islands, 33 percent were from urban areas. There were about 67 percent Hindu households, 10 percent Muslim and 22 percent Christian households in the sample. Seventeen percent of the households belonged to either scheduled castes or scheduled tribes. Twenty-seven percent of the households lived in *Kachchahouses* and about 22 percent are in *Semi-pacca* and 51 percent are in *pucca* houses. About half of the households belonged to high economic status (51 percent in high SLI)

About 86 percent of population aged seven and above are literate. Percent literate among females is 81, whereas it is 90 percent for males. Proportion of non-literate is much higher among the older cohort compared to the younger ones. Twenty-two percent of eligible women in the UT are non-literate, and 29 percent have completed 10 or more years of schooling. In Andamans & Nicobar Islands the levels of literacy among the eligible women and their husbands are high. As regards distribution of non-literate women, lesser proportion of younger women below age 30 are illiterate compared to older women age 30 and above, but in case of non-literate husbands the proportion is more for husbands aged 25-44 years.

The reporting of the marriages during three years prior to survey gives the mean age at marriage among the boys and girls in the UT as 25.9 and 21.4 years respectively. Only four percent of boys as well as girls in the UT got married before attaining the minimum legal age at marriage of 21 and 18 years respectively. In Andamans district, 3 percent each of the boys the girls got married below the legal minimum age at marriage, while 7 percent of the boys and 9 percent of the girls in Nicobars district did so.

Most of the households (95 percent) use cooking salt that is iodized at the recommended level of 15 parts per million or higher level of iodine content, while only 0.2 percent of households used salts that are not iodized at all. A majority of the households in both Andamans (96 percent) and Nicobars (89 percent) districts consume adequately iodized salt.

On an average, women on the verge of completion of reproductive period have given birth to 2.8 children. The completed fertility is almost the same in both the districts (2.8 children in Andamans and 2.7 children in Nicobars).

The share of births of order 3 and above in the total births that occurred three years prior to survey is 21 percent. The proportion of higher order births is relatively higher in Nicobars district (27 percent) compared to Andamans district (16 percent).

The data collected on the utilization of ANC services for the women who had their last live/still birth during three years prior to survey shows that the ANC coverage in the UT is quite high as 97 percent of the women received at least one ante-natal care during pregnancy. About one percent of the women during their pregnancy were visited by health worker only at their residence for providing ANC. Most of the women (94 percent) received ANC from government health facilities, while only one percent visited private health facilities. The percent of women who got some kind of ANC during pregnancy is 98 percent in Andamans district and 97 percent in Nicobars district.

Most of the women in Andamans & Nicobar Islands had check-up of weight (99 percent), blood pressure (99 percent) and abdomen (94 percent). Eighty-four percent women received Iron and Folic Acid (IFA) tablets and 98 percent got at least one TT injection. A full package of ANC including minimum three ANC visits, at least one TT injection and 100 or more IFA tablets/Syrup was received by as high as 78 percent of women.

Minimum three ANC and timing of first check-up is crucial for maternal and child care. In Andamans & Nicobar Islands nearly 47 percent of women got ANC in the first trimester and 94 percent had minimum three antenatal check-ups. The extent of ANC in first trimester does not vary much in Andamans (49 percent) and Nicobars (44 percent) districts. Most of the women in Andamans (97 percent) as well as in Nicobars (91 percent) had got minimum three ANC.

Nearly 76 percent of the total deliveries in Andamans & Nicobar Islands were conducted in the health institutions; 8 percentage points up from RCH Round I. Most of the institutional deliveries were conducted in government institutions (71 percent of total deliveries) as against in private institutions (5 percent of total deliveries). Ten percent of the total deliveries, that took place at home, were assisted by midwifery trained persons i.e. doctor/ nurse and ANM. So in all, 78 percent of the deliveries, slightly up from RCH Round I (71 percent), in the UT were assisted by skilled personnel. The extent of institutional deliveries does not vary much in Andamans (79 percent) and Nicobars (72 percent) districts. The percent of the institutional deliveries increases with women's education and economic status.

In Andamans & Nicobar Islands, 15, 12 and 7 percent of the women experienced pregnancy, delivery and post-delivery complications respectively. About 93 percent of the women sought treatment for the pregnancy as well as for the post-delivery complications. The proportion of women experiencing pregnancy complications is higher in Andamans district (20 percent) than in Nicobars district (9 percent). The incidence of all the three types of complications seems to be linked with each other. In Andamans district where the incidence of pregnancy complications is high, the incidence of delivery and post-delivery complications is also high.

In both the districts and the UT as a whole, the practice of breast-feeding is almost universal. However, the practice of initiation of breastfeeding within two hours of birth of the child is not common. In Andamans & Nicobar Islands, nearly 66 percent women started breastfeeding the child within two hours of birth and 11 percent started after one day of birth. There is variation in the pattern of breastfeeding in the two districts. In Andamans district nearly 57 percent of the women breastfed the children within two hours of birth, whereas it is 72 percent in Nicobars district.

In Andamans & Nicobar Islands 98, 86, 76 and 86 percent of the children received the BCG vaccine, three doses of DPT, three doses of Polio and measles vaccine respectively. There is 22 percentage points drop from BCG to polio and it increased by 10 percentage points from polio to measles. It means that a sizeable number of children that have contact with services providers are missed out of subsequent services. The complete schedule of immunization including BCG, three doses of DPT and Polio each and measles was received by 69 percent of the children, while one percent of the children did not receive a single vaccination under routine programme. About 78 percent of the children received supplementation of at least one dose of vitamin A and only 2 percent children received IFA tablets/liquid for iron supplementation.

The extent of complete immunization consisting of BCG, three injections of DPT, three doses of Polio and measles is lower in Andamans district (58 percent) as compared to Nicobars district (79 percent).

In Andamans & Nicobar Islands, 60 percent of the women were aware of diarrhoea management and 50 percent were aware of Oral Rehydration Salt (ORS). During the two-week period prior to survey, children of 8 percent of the women suffered from diarrhoea. And 82 percent women treated diarrhoea among children by giving ORS. In comparison to awareness about diarrhoea management, the awareness about danger signs of pneumonia is quite low. Only 16 percent of the women reported awareness about danger signs of pneumonia. Twelve percent of the women reported that their children suffered from cough, cold and difficulty in breathing in two-week period prior to survey and 91 percent sought treatment.

The knowledge of family planning methods is almost universal in both the districts of Andamans & Nicobar Islands, with over 97 percent women reporting knowledge of one method or the other. However, the knowledge of any spacing method is relatively low, but the proportion *per se* is high (72 percent). The knowledge of any modern methods is also universal in both the districts, though the knowledge of all modern methods is only 26 percent. The proportion

knowing all modern methods (male and female sterilization, IUD, oral pills and condom) is much higher in Andamans district (82 percent) than in Nicobars district (61 percent).

In DLHS, knowledge about No-scalpel vasectomy has been asked to husbands of eligible women. Only one-tenth of the husbands were aware of no-scalpel vasectomy in the UT. The proportion of husbands knowing No-scalpel vasectomy is 10 percent in Andamans and 13 percent in Nicobars district.

The contraceptive prevalence rate (any methods) in the UT is 58 percent, 4 percentage points down from RCH Round I, comprising of prevalence of about 57 percent of modern methods and only 0.7 percent of traditional methods. Forty-six percent of the couples adopted sterilization. The percent users of the two male methods - sterilization and condom is only 5 percent. There has been positive association between contraceptive use and economic development, while no such variation is found in the case of female education. The contraceptive prevalence is slightly higher in Andamans district (60 percent) than in Nicobars district (57 percent).

In Andamans & Nicobar Islands, a total of 26 percent of women are found to have unmet need for family planning, with 15 percent for limiting and 11 percent for spacing. Almost the same proportion of women are found to have unmet need in the two districts both for limiting and spacing.

Only 9 percent of the women in the UT reported that either ANM/LHV or health worker visited them at their residence at least once in the past three months. Nearly 87 percent of women who were visited by ANM felt that ANM had given them sufficient time to discuss health-related matters.

In Andamans district nearly 8 percent of the women reported the visit of ANM/LHV to their residence, while this proportion is marginally higher in Nicobar district (15 percent).

It has been observed that in three months period prior to survey, 18 percent of the eligible women who were required to consult health facility visited any of the government health facilities. Very small proportion of the women who visited the health facility rated facility as excellent.

The utilization of the government health facilities is more in Andamans (95 percent) as well as in Nicobars (99 percent). A small proportion of women (3 percent) visited to private health facilities - 4 percent in Andamans and 2 percent in Nicobars district.

In Andamans & Nicobar Islands 15 and 72 percent of women are aware of RTI/STI and HIV/AIDS respectively. The corresponding levels of awareness among husbands of eligible women are 53 and 78 percent. The proportions of women who are aware of RTI/STI and HIV/AIDS are lower in Nicobars district (7 and 67 percent respectively) than in Andamans district (24 and 76 percent respectively). Similarly awareness levels of husbands of eligible women of RTI/STI and HIV/AIDS are lowest in Nicobars district (17 and 70 percent respectively) than in Andamans district (58 and 79 percent respectively).

About 6 percent of women and 5 percent of husbands of eligible women in the UT reported having at least one symptoms of RTI/STI. In Andamans district, the reported prevalence of RTI/STI among husbands was lower, while it is slightly lower in Nicobars district. The prevalence of RTI/STI for women is 9.7 percent in Andamans and 1.9 percent in Nicobars district and the corresponding figures for husbands are 5.2 and 1.2 percent. Three percent of women reported vaginal discharge with 4.7 percent in Andamans and 1.4 percent in Nicobars district. Fifty-nine percent of women sought treatment for vaginal discharge problem and 61 percent of husbands with at least one symptom of RTI/STI sought treatment.

CHAPTER I

INTRODUCTION

1.1 Background and Objectives of the Survey

The Reproductive and Child Health (RCH) programme that has been launched by Government of India (GoI) in 1996-97 is expected to provide quality services and achieve multiple objectives. It ushered a positive paradigm shift from method-oriented, target-based activity to providing client-centred, demand-driven quality services. Also, efforts are being made to reorient provider's attitude at grassroots level and to strengthen the services at outreach levels.

The new approach requires decentralization of planning, monitoring and evaluation of the services. The district being the basic nucleus of planning and implementation of the RCH programme, Government of India has been interested in generating district level data on utilization of the services provided by government health facilities, other than that based on service statistics. It is also of interest to assess people's perceptions on quality of services. Therefore, it was decided to undertake District Level Household Survey (DLHS) under the RCH programme in the country.

The Round I of RCH survey was conducted during the year 1998-99 in two phases (each phase covered half of the districts from all states/union territories) in 504 districts for which International Institute for Population Sciences (IIPS), Mumbai was designated as the nodal agency.

In Round II, survey was completed during 2002-04 in 593 districts as per the 2001 Census. In DLHS-RCH, information about RCH has been collected using a slightly modified questionnaire. In Round II, some new dimensions, such as test of cooking salt to assess the consumption of salt fortified with iodine, collection of blood of children, adolescents and pregnant women to assess the level of anaemia, and measurement of weight of children to assess the nutritional status, were incorporated.

The main focus of the DLHS-RCH has been on the following aspects:

- Coverage of ANC & immunization services
- Proportion of safe deliveries
- Contraceptive prevalence rates
- Unmet need for family planning
- Awareness about RTI/ STI and HIV/AIDS
- Utilization of government health services and users' satisfaction.

For the purpose of conducting DLHS-RCH, all the states and the union territories were grouped into 16 regions. A total of twelve research organizations including Population Research Centres (PRCs) were involved in conducting the survey in 16 regions with IIPS as the nodal agency.

1.2 Survey Design

In Round II, a systematic, multi-stage stratified sampling design was adopted. In each district, 40 Primary Sampling Units (PSUs – Villages/Urban Frame Size) were selected with probability proportional to size (PPS) using the 1991 Census data. All the villages were stratified according to population size, and female literacy was used for implicit arrangement within each strata. The number of PSUs in rural and urban areas was decided on the basis of percent of urban population in the district. However, a minimum of 12 urban PSUs were selected in each district in case the percent urban was low. The target sample size in each district was set at 1,000 complete residential households from 40 selected PSUs. In the second stage, within each PSU, 28 residential households were selected with Circular Systematic Random Sampling (CSRS) procedure after house listing. In order to take care of non-response due to various reasons, sample was inflated by 10 percent (i.e. 1,100 households).

For selecting the urban sample, the National Sample Survey Organization (NSSO) provided the list of selected urban frame size (UFS) blocks in the district. The UFS blocks were made available separately for each district for urban areas. The maps of selected blocks were obtained from the NSSO field office located in each state/union-territory.

But in each union territory, in two districts, the PSUs that were surveyed in Round I of DLHS-RCH (also known as RHS-RCH) were also selected for survey in Round II. This was done in order to measure the changes more accurately. Two districts, one with the highest proportion of safe delivery and another with the lowest proportion of safe delivery among those surveyed during Round I of the survey were selected for this purpose. In all other districts, fresh sample of PSUs were selected.

1.3 House Listing and Sample Selection

The household listing operation was carried out in each of the selected PSU segment prior to the data collection that provided the necessary frame for selecting the households. The household listing operation also involved preparation of location map and layout sketch map of the structures and recording the details of the households in these structures in each selected PSU. This exercise was carried out by independent teams each comprising one lister, one mapper and one supervisor under the overall guidance and monitoring of the survey coordinator of households of the selected regional agencies.

A complete listing of households was carried out in villages with households up to 300. In case of villages with more than 300 households but less than or equal to 600 households, two segments of more or less same size were formed and one segment was selected at random and household listing was carried out. In case of villages with more than 600 households, segments each of about 150 households were formed and two segments were selected for listing using the systematic random sampling method.

Small villages with less than 50 households were linked with a nearest village. After combining it with the nearest village, the same sampling procedure was adopted as mentioned above.

For the urban PSUs, the selected UFS blocks needed no segmentation as they were of almost equal size and contained less than 300 households.

No replacement was made if selected household was absent during data collection. However, if a PSU was inaccessible, a replacement PSU with similar characteristics was selected by the IIPS and provided to the regional agency for survey.

1.4 Questionnaires

DLHS-RCH collected information on various indicators pertaining to RCH that would assist policymakers and programme managers to formulate and implement the goals set for RCH programmes. The International Institute for Population Sciences (IIPS), Mumbai, the Nodal Agency for DLHS–RCH project has made necessary modifications in the two Questionnaires: Households Questionnaire and Women’s Questionnaire and added three more Questionnaires i.e., Husband’s Questionnaire, Village Questionnaire and Health Questionnaire, in consultation with MoHFW and World Bank. These Questionnaires were discussed and finalized in training cum workshop organized at IIPS during the first week of November 2001.

These modified questionnaires had been canvassed for round II of the DLHS–RCH survey, taking into consideration the views of all the regional agencies involved. The house–listing teams and the interviewers and the supervisors for the main survey were given rigorous training based on the manuals developed for the purpose by the Nodal Agency.

All the questionnaires were bilingual, with questions in both regional and English language.

The Details of questionnaires are as follows:

Household Questionnaire: The household questionnaire lists all usual residents in each sample household including visitors who stayed in the household the night before the interview. For each listed household member, the survey collected basic information on age, sex, and marital status, relationship to the head of the household, education and the prevalence/incidence of tuberculosis, blindness and malaria. Information was also collected on the main source of drinking water, type of toilet facility, source of lighting, type of cooking fuel, religion and caste of household head and ownership of other durable goods in the household. In addition, a test was conducted to assess whether the household used cooking salt that has been fortified with iodine. Besides, details of marriages and deaths which happened to usual residents within reference period were collected. Efforts were also made to get information about maternal deaths.

Women Questionnaire: Women questionnaire is designed to collect information from currently married women age 15 – 44 years who are usual residents of the sample household or visitors who stayed in the sample household the night before the interview. The women questionnaire covered the following sections:

Section I: Background Characteristics: In this section the information collected on age, educational status and birth and death history of biological children including still birth, induced and spontaneous abortions.

Section II: Antenatal, Natal and Post natal Care: In this section the questionnaire collects information only from the women who had live birth, still birth, spontaneous or induced abortion during last three years preceding the survey date. The information on whether women received antenatal and postpartum care, who attended the delivery and the nature of complications during pregnancy, delivery and post-partum for recent births were also collected.

Section III: Immunization and childcare: This section gives information about feeding practices, the length of breastfeeding, immunization coverage and recent occurrence of diarrhoea, and pneumonia for young children (below age 3 years).

Section IV: Contraception: This section provides information on knowledge and use of specific family planning methods. Questions were included about reasons for non-use, intentions about future use, desire for additional child, sex preference for next child etc.

Section V: Assessment of quality of Government health services and client satisfaction. In this section the questions are targeted to assess the quality of family planning and health services provided by Government health facilities. The information was also collected about the rating of Government health facilities and staff and reasons for not visiting government health facilities by eligible woman.

Section VI: Awareness about RTI/STI and HIV/AIDS: In this section the information was collected about women's knowledge of RTI/STI, source of knowledge, aware of mode of transmission, curability, symptoms and treatment seeking behaviour. About HIV/AIDS; Awareness, Source of knowledge, aware of mode of transmission and prevention etc. were canvassed.

Husband Questionnaire: In DLHS-RCH, round II, husband questionnaire was used to collect information from eligible women's husbands about age, educational status, knowledge and source of knowledge of RTI/STI and HIV/AIDS, reported symptoms of RTI/STI and male participation. Apart from these, information on desires for children, reasons for not using F.P. methods, future intention to use F.P. methods and knowledge about no scalpel vasectomy (NSV) has also been collected.

Health Questionnaire: In DLHS-RCH, round II, a health questionnaire is included. The information collected was on weight of children age 0–71 months old and the blood samples to assess the haemoglobin levels of children age 0–71 months old, adolescent girls age 10–19 years old and pregnant eligible women. This information is useful for assessing the levels of nutrition prevailing in the population and prevalence of anaemia among women, adolescent girls and children.

Village Questionnaire: A village questionnaire is also added in this round of DLHS. The information collected was on the availability and accessibility of various facilities in the village, especially on accessibility of educational and health facilities.

1.5 Fieldwork and Sample Coverage

The fieldwork for RCH Round II was done in two phases. During Phase I, one district was covered in May 2003 and the other district was covered during Phase II in November 2004.

During Round II, a total of 2,175 households were covered. From these surveyed households, 1,767 currently married women (aged 15-44 years) and 1,140 husbands of eligible women were interviewed.

1.6 Data processing

All the five types of completed questionnaires were brought to the headquarter of regional agencies and data were processed using microcomputers. The process consisted of office editing of questionnaires, data entry, data cleaning and tabulation. Data cleaning included validation, range and consistency checks. For both data entry and tabulation of the data, IIPS developed the software package. The district and state level reports were prepared by regional agency whereas national report is prepared by the nodal agency.

1.7 Sample Weights

In generating district level demographic indicator, sample weights for household, women and husband have been used and these weights for a particular district are based on three selection probabilities f_1^i , f_2^i and f_3^i pertaining to i^{th} PSU of the district. These probabilities are defined as

$$\begin{aligned} f_1^i &= \text{Probability of selection of } i^{\text{th}} \text{ PSU in a district} \\ &= \frac{(n_r * H_i)}{H} \end{aligned}$$

Where, n_r is the number of rural PSU to be selected in a district, H_i refers to the number of household in the i^{th} PSU and $H = \sum H_i$, total number of household in a district.

$$\begin{aligned} f_2^i &= \text{Probability of selecting segment (s) from segmented PSU} \\ &\quad \text{(in case the } i^{\text{th}} \text{ selected PSU is segmented)} \\ &= \text{(Number of segments selected after segmentation of PSU) / (number of segment created in} \\ &\quad \text{a PSU)} \end{aligned}$$

The value of f_2^i is to be equal to one for un-segmented PSU.

$$\begin{aligned} f_3^i &= \text{probability of selecting a household from the total listed households of a PSU or in} \\ &\quad \text{segment(s) of a PSU} \\ &= \frac{28 * HR_i}{HL_i} \end{aligned}$$

Where HR_i is the household response rate of the i^{th} sampled PSU and HL_i is the number of households listed in i^{th} PSU in a district.

For urban PSU, f_1^i is computed either as the ratio of number of urban PSUs to be included from the district to the total number of UFS blocks of the district or as the ratio of urban population of the selected PSU to the total urban population of the district.

The probability of selecting a household from the district works out as;

$$f^i = (f_1^i * f_2^i * f_3^i)$$

The non-normalized household weight for the i^{th} PSU of the district is, $w^i = \frac{1}{f^i}$, while the normalized weight used in the generation of district indicators is

$$n_i^d = \frac{\sum_i n_i}{\sum_i n_i * w^i} * w^i, \quad i=1,2,3,\dots,40.$$

Where n_i is the number of households interviewed in the i^{th} PSU. The weight for women and husband are computed in the similar manner after multiplication of expression for f^i by the corresponding response rate. State weights for households, women and husbands are further derived from the district weights n_i^d for the i^{th} psu in d^{th} district using external control so that for sample results do not deviate from the corresponding information about the population.

Let, $n_s = \sum_i n_i^d$ and $N_t = \sum_i N_i^d$, denote the number of households in the sample and census of a particular state, then state level households weights are worked out as;

$$n_i^s = n_i^d * \frac{\left(\frac{n_i^d}{n_s} \right)}{\left(\frac{N_i^d}{N_{sc}} \right)}, \quad \text{where } n_i^d \text{ household sample in } i^{\text{th}} \text{ district, } n_s \text{ is the total sample in}$$

the state, N_i^d is the census population in the i^{th} district and N_{sc} is the census population in the state.

These households' weights are controlled for rural-urban separately.

Considering sample and census currently married women in 15-44 years and married males above 15 years for specified state by districts and rural-urban residence, state level women and husbands' weights are obtained for estimation of state level indicators.

1.8 Sample Implementation

Table 1.1 shows the period of fieldwork, number of households interviewed and households response rates. A total of 2,175 households are interviewed out of which, 1,767 were rural. The overall household response rate – the number of households interviewed per 100 occupied households – was 98. The household response rate was 98 percent in both the districts.

Table 1.1 NUMBER OF HOUSEHOLDS INTERVIEWED						
Month and year of fieldwork and number of households interviewed by district, Andaman & Nicobar Islands, 2002-04						
State/District	Month and year of field work		Number of households interviewed			Response rate
	From	To	Total	Rural	Urban	
UT	-	-	2,175	1,767	408	97.8
UT-phase I	05/2003	05/2003	-	-	-	-
UT-phase II	11/2004	11/2004	-	-	-	-
Andamans	05/2003	05/2003	1,091	683	408	97.6
Nicobars	11/2004	11/2004	1,084	1,084	-	97.9

Note: Table based on unweighted cases.

In the interviewed households, interviews were completed with 1,767 currently married women who are the usual members of the households or stayed night before the household interview and 1,140 husbands of eligible women were also interviewed (Table 1.2). The number of completed interviews per 100 identified eligible women and husbands in the households with completed interviews were 90 and 59 respectively. The women's response rate was higher in Andamans district (93 percent) than in Nicobars district (88 percent). However, husbands' response rate was found to be higher in Nicobars district (65 percent) than in Andamans district (53 percent).

Table 1.2 NUMBER OF WOMEN AND HUSBANDS INTERVIEWED								
Number of women and husbands interviewed by district, Andaman & Nicobar Islands, 2002-04								
State/District	Number of women interviewed			Response rate	Number of husbands interviewed			Response rate
	Total	Rural	Urban		Total	Rural	Urban	
UT	1,767	1,452	315	90.3	1,140	982	158	59.1
Andamans	894	579	315	93.1	494	336	158	52.7
Nicobars	873	873	0	87.7	646	646	0	65.1

Note: Based on unweighted cases.

1.9 Basic Demographic Profile of the Union Territory

Before presenting the survey results, the basic demographic features of Andaman & Nicobar Islands and its districts (as per census, 2001) are presented here.

The union territory of Andaman & Nicobar Islands are located in Bay of Bengal. The union territory consisted of two districts: Andamans and Nicobars. There are 5 sub-districts (C.D.Blocks) and 547 villages in the two districts of the union territory. The urban areas of the union territory comprised one town and two census towns in 2001. Port Blair is the capital of the union territory.

According to 2001 census the population of Andaman & Nicobar Islands is 356.2 thousands out of which 193.0 thousands are males and 163.2 thousands are females. The rural and urban break-up of the population shows that 67.3 percent of the population was enumerated in rural areas and 32.7 percent in urban areas. Unlike the decline at national level, the union territory of Andaman & Nicobar Islands has recorded a sharp decline in the decadal growth rate from 48.7 per cent in 1981-91 to 26.9 percent during 1991-2001. Among the districts, Andamans with 30.1 percent has much higher decadal growth rate than Nicobars, which recorded 7.3 percent growth rate of total population during 1991-2001.

Percentage of Scheduled tribe population has experienced a decline by 1.2 percentage points during 1991-2001, in the union territory. The proportions of schedule tribe population in total population of 2001 is 8.3 percent. With a population density of 43 persons per sq. km., the union territory of Andaman & Nicobar Islands ranks 33rd among the states and union territories in India and this figure is much lower than the all India density of 325 persons per sq. km. Among the districts, Andamans has the density (49 persons/sq. km.) higher than that of Nicobars (23 persons/sq. km.).

The sex ratio of the total population in the union territory has improved significantly since 1991 Census from 818 to 846 females per 1000 males. Nicobars has recorded the sex ratio (857) higher than Andamans (844) within the union territory.

The literacy rate in the union territory has improved from 73.0 percent in 1991 to 81.2 percent in 2001, and, it is much higher than the national average of 64.8 percent. Among the districts, Andamans has literacy rate of 82.4 percent, which is higher than the literacy rate of 72.4 percent of Nicobars. The male literacy rate for the union territory is 86.3 percent and the female literacy rate is 75.2 percent. Both the rates have increased from 1991 census to 2001 census.

Table 1.3 BASIC DEMOGRAPHIC INDICATORS							
Basic demographic indicators of India, union territory and districts, Census 2001							
India/union territory/district	Population (in thousand)	Percentage urban	Percentage decadal growth rate ¹	Sex ratio ²	Percentage literate 7+		
					Male	Female	Persons
India	1,028,737	28.0	21.5	933	75.8	53.7	64.8
UT	356.15	32.7	26.9	846	86.3	75.2	81.2
Andamans	314.08	37.0	30.1	844	87.4	76.6	82.4
Nicobars	42.07	0.0	7.3	857	78.6	65.0	72.4

Source: Primary Census Abstract, Andaman & Nicobar Islands, Census of India, 2001. ¹ 1991-2001, ² Females per 1,000 males.

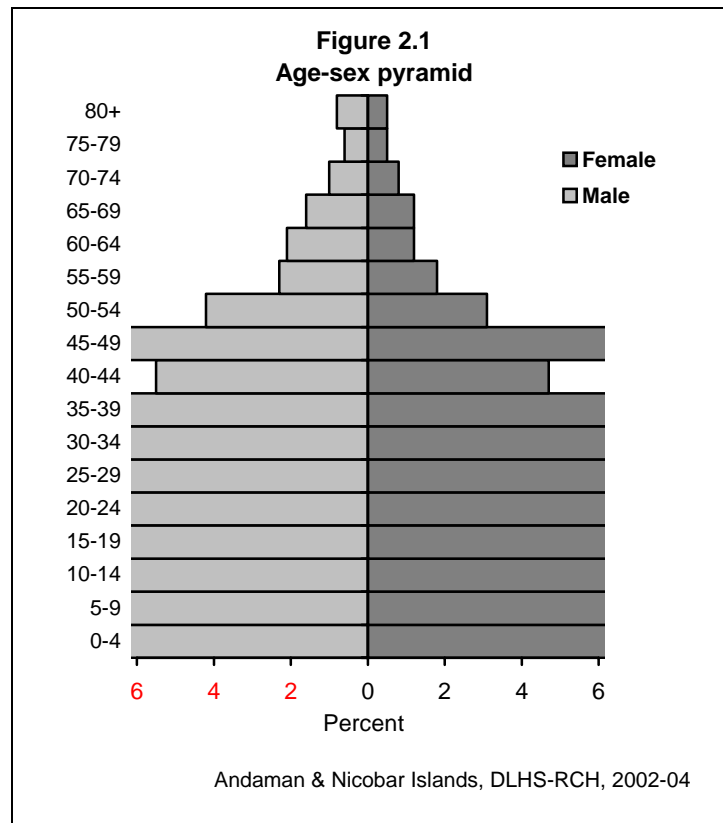
CHAPTER II

BACKGROUND CHARACTERISTICS OF HOUSEHOLD

This chapter provides a socio-economic and demographic profile of households interviewed in the District Level Household Survey-Reproductive and Child Health. Facilities and services such as Health, Education and Communication available in the representative sampled villages are also presented here. The *de facto* procedure of enumeration is adopted in order to include every individual staying in the sampled Primary Sampling Units (PSU), either a village or an urban area, the night before the survey. The objective of adopting the *de facto* method is to avoid duplication of persons who are in transit.

2.1 Age –Sex Structure

The age-sex distribution of sampled household population classified by residence is presented in Table 2.1. The percent distribution is based on sampled *de facto* population of 10,581 persons of whom 68 percent lived in the rural areas of Andaman & Nicobar Islands. The union territory of Andaman & Nicobar Islands depicts a young and growing population with 30 percent below the age of 15 years (Figure 2.1). There are slightly more children below 15 years recorded in rural areas (31 percent) compared to those in urban areas (27 percent).



The overall sex ratio of 107 males per 100 females is recorded for the *de facto* population. The sex ratio is marginally more skewed, 108 in favour of males in urban areas compared to 107 in rural areas.

Table 2.1 HOUSEHOLD POPULATION BY AGE AND SEX									
Percent distribution of the household population by age and by residence and sex, Andaman & Nicobar Islands, 2002-04									
Age	Total			Rural			Urban		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
<1	1.9	1.8	2.0	2.0	1.9	2.0	1.7	1.4	2.0
1-4	7.9	8.0	7.7	7.7	7.8	7.5	8.3	8.4	8.3
5-9	10.0	10.0	9.9	11.0	11.3	10.7	7.7	7.3	8.1
10-14	10.4	10.1	10.7	10.7	10.0	11.5	9.7	10.3	9.0
15-19	10.4	11.0	9.8	10.3	11.3	9.2	10.8	10.3	11.3
20-24	10.2	8.1	12.5	10.0	7.7	12.6	10.7	9.1	12.4
25-29	10.2	9.1	11.4	9.7	8.8	10.7	11.3	9.7	12.9
30-34	8.6	8.7	8.3	8.3	8.0	8.6	9.2	10.4	7.8
35-39	7.9	8.3	7.5	7.8	8.1	7.4	8.3	8.8	7.8
40-44	5.2	5.5	4.7	5.4	5.4	5.4	4.6	5.9	3.2
45-49	6.4	6.6	6.3	6.5	7.1	5.8	6.3	5.6	7.2
50-54	3.7	4.2	3.1	3.4	4.5	2.2	4.2	3.6	4.9
55-59	2.0	2.3	1.8	2.0	1.9	2.0	2.2	3.1	1.3
60-64	1.7	2.1	1.2	1.7	1.9	1.4	1.7	2.6	0.8
65-69	1.4	1.6	1.2	1.4	1.6	1.1	1.5	1.6	1.4
70-74	0.9	1.0	0.8	1.0	1.1	0.9	0.8	0.9	0.7
75-79	0.6	0.6	0.5	0.6	0.8	0.5	0.5	0.3	0.7
80+	0.6	0.8	0.5	0.7	0.8	0.6	0.6	0.8	0.3
Total percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of persons	10,581	5,479	5,101	7,210	3,729	3,480	3,371	1,750	1,621
Sex ratio ¹	107	NA	NA	107	NA	NA	108	NA	NA

Note: Table is based on the *de facto* population, i.e. persons who stayed in the household the night before the interview (including both usual residents and visitors). NA: Not applicable. ¹ Males per 100 females

2.2 Household Characteristics

The percent distribution of 2,175 households surveyed in the union territory of Andaman & Nicobar Islands by selected characteristics of the household head and the number of usual household members are shown in Table 2.2. This is based on *de jure*, the usual resident population. About 92 percent of household heads are male, slightly varied by place of residence, while only 8 percent are female-headed households. About 75 percent of household heads are in the 30-59 years age group. The median age of household heads is 44 years for the union territory as a whole and in urban areas, while it is 45 years in rural areas. Seven percent of household heads are younger than 30 years and about 18 percent are at least 60 years old. Majority of the household heads are Hindus (67 percent), 10 percent are Muslims, and 22 percent are Christians. Christians constitute a higher proportion of population in rural areas (27 percent) than in urban areas (12 percent). Only 5 percent of the rural households are Muslims, while 18 percent of the urban households are Muslims.

Table 2.2 HOUSEHOLD CHARACTERISTICS			
Percent distribution of the households by selected characteristics of the household head and household size, according to residence, Andaman and Nicobar Islands, 2002-04			
Characteristic	Total	Residence	
		Rural	Urban
Sex of the household head			
Male	91.6	92.8	89.2
Female	8.4	7.2	10.8
Age of the household head			
< 30	7.0	6.9	7.0
30-44	41.9	41.1	43.3
45-59	32.8	33.1	32.2
60+	18.4	18.8	17.5
Median age of the household head	44.4	44.5	44.1
Religion of the household head			
Hindu	67.3	66.6	68.9
Muslim	9.6	5.4	18.3
Christian	22.1	27.1	11.9
Sikh	0.7	0.7	0.7
Buddhist	0.1	0.1	0.2
Jain	0.1	0.1	0.0
Caste/tribe of the household head			
Scheduled caste	9.1	12.2	2.8
Scheduled tribe	8.3	11.5	1.7
Other backward class	2.1	2.3	1.6
Other #	69.9	62.3	85.2
Don't know	10.7	11.6	8.7
Number of usual members			
1	0.3	0.2	0.5
2	4.6	4.4	5.4
3	15.3	14.3	19.3
4	31.5	31.1	33.2
5	21.6	22.4	18.0
6	11.5	11.3	12.3
7	7.0	7.5	4.9
8	3.1	3.1	3.0
9+	5.1	5.5	3.4
Mean household size	4.8	4.8	4.5
Total percent	100.0	100.0	100.0
Number of households	2,175	1,458	717
Note: Table is based on the <i>de jure</i> population. # Higher caste (Not belonging to a scheduled caste, a scheduled tribe and an other backward class).			

Nearly 9 percent of the households in Andaman & Nicobar Islands belong to schedule caste, 8 percent to schedule tribe and 2 percent to other backward classes, while 70 percent of the households are headed by other castes not under schedule caste, schedule tribe and other backward classes. About 24 percent of the household heads belong to schedule caste or tribe in rural areas and it is only 5 percent in urban areas. The overall union territory average household size is 4.8 persons. The rural-urban differential in average household size is 4.8 in rural areas and 4.5 in urban areas.

2.3 Educational Level

The educational background of Andaman & Nicobar Islands presented in this section is based on *de facto* household population. Level of literacy and years of schooling, according to age, sex and residence are shown in Table 2.3.

Table 2.3 EDUCATIONAL LEVEL OF THE HOUSEHOLD POPULATION									
Percent distribution of household population age 7 and above by literacy level and years of schooling, according to age, residence and sex, Andaman & Nicobar Islands, 2002-04									
Age	Non-literate	Literate but no schooling	Years of schooling				Missing	Total Percent	Number of persons
			1-5	6-8	9-10	11 or more			
Total									
Male									
7-9	6.7	0.6	92.8	0.0	0.0	0.0	0.0	100.0	304
10-14	1.4	0.2	47.1	45.6	5.4	0.0	0.2	100.0	554
15-19	2.4	0.2	7.9	27.9	38.6	23.0	0.0	100.0	601
20-29	4.0	0.0	7.7	20.1	34.9	33.3	0.0	100.0	946
30-39	8.4	0.3	11.0	22.0	24.5	33.8	0.0	100.0	936
40-49	14.9	0.0	17.7	20.3	22.2	24.8	0.0	100.0	667
50+	30.4	0.6	29.7	15.4	14.8	9.0	0.0	100.0	689
Total	10.0	0.2	23.2	22.5	22.8	21.2	0.0	100.0	4,697
Female									
7-9	11.6	0.0	88.4	0.0	0.0	0.0	0.0	100.0	276
10-14	1.0	0.0	39.1	50.4	9.4	0.0	0.1	100.0	546
15-19	2.0	0.0	6.8	23.3	43.5	24.3	0.0	100.0	502
20-29	8.4	0.3	10.0	16.9	30.5	33.9	0.0	100.0	1,218
30-39	22.1	0.2	13.2	19.0	24.2	21.4	0.0	100.0	809
40-49	39.4	0.3	17.1	20.2	12.1	10.9	0.0	100.0	560
50+	62.5	1.0	15.3	9.9	9.8	1.5	0.0	100.0	465
Total	19.2	0.3	20.3	20.8	21.7	17.7	0.0	100.0	4,377
Total									
7-9	9.0	0.3	90.7	0.0	0.0	0.0	0.0	100.0	580
10-14	1.2	0.1	43.2	48.0	7.3	0.0	0.1	100.0	1,100
15-19	2.2	0.1	7.4	25.8	40.9	23.6	0.0	100.0	1,103
20-29	6.5	0.2	9.0	18.3	32.4	33.6	0.0	100.0	2,164
30-39	14.7	0.2	12.0	20.6	24.3	28.1	0.0	100.0	1,745
40-49	26.1	0.1	17.5	20.2	17.6	18.5	0.0	100.0	1,227
50+	43.3	0.8	23.9	13.2	12.8	5.9	0.0	100.0	1,154
Total	14.4	0.2	21.8	21.7	22.3	19.5	0.0	100.0	9,074
Note: Table is based on <i>de facto</i> population									Contd.

Table 2.3 indicates that about 14 percent of the population aged seven and above are non-literate. The proportion of non-literates is 19 percent for females compared to 10 percent for males. The proportion of non-literate is much higher among the older cohorts compared to the younger ones. For both males and females, going by expected trend, the level of literacy is higher in the younger population than in the older age groups with the exception of the youngest age group of 7-9 years (Figure 2.2).

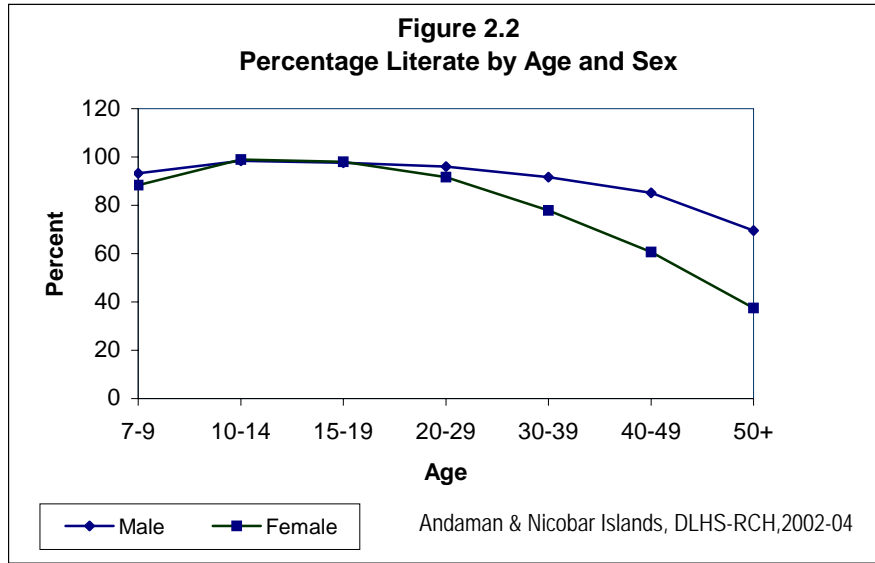


Table 2.3 EDUCATIONAL LEVEL OF THE HOUSEHOLD POPULATION

Percent distribution of household population age 7 and above by literacy level and years of schooling, according to age, residence and sex, Andaman & Nicobar Islands, 2002-04

Age	Non-literate	Literate but no schooling	Years of schooling				Missing	Total Percent	Number of persons
			1-5	6-8	9-10	11 or more			
RURAL									
Male									
7-9	6.0	0.0	94.0	0.0	0.0	0.0	0.0	100.0	221
10-14	1.2	0.3	45.3	48.6	4.3	0.0	0.3	100.0	374
15-19	1.7	0.3	9.5	28.6	39.3	20.6	0.0	100.0	420
20-29	5.0	0.0	10.6	21.5	34.7	28.3	0.0	100.0	617
30-39	10.1	0.4	12.4	25.8	22.6	28.7	0.0	100.0	601
40-49	17.1	0.0	19.2	20.5	20.7	22.5	0.0	100.0	466
50+	30.5	0.6	33.2	16.9	11.4	7.4	0.0	100.0	466
Total	10.7	0.2	25.3	24.1	21.5	18.1	0.0	100.0	3,164
Female									
7-9	10.4	0.0	89.6	0.0	0.0	0.0	0.0	100.0	212
10-14	1.4	0.0	37.5	51.7	9.3	0.0	0.1	100.0	400
15-19	2.6	0.0	8.4	27.1	45.7	16.2	0.0	100.0	319
20-29	8.4	0.5	12.0	18.9	33.1	27.2	0.0	100.0	808
30-39	25.3	0.2	14.5	20.1	23.8	16.1	0.0	100.0	556
40-49	43.2	0.4	17.7	19.1	10.3	9.4	0.0	100.0	392
50+	67.0	0.4	15.6	9.0	6.3	1.7	0.0	100.0	302
Total	20.6	0.3	22.1	22.1	21.5	13.5	0.0	100.0	2,990
Total									
7-9	8.2	0.0	91.8	0.0	0.0	0.0	0.0	100.0	433
10-14	1.3	0.2	41.3	50.2	6.9	0.0	0.2	100.0	774
15-19	2.1	0.2	9.1	27.9	42.1	18.7	0.0	100.0	739
20-29	6.9	0.3	11.4	20.0	33.8	27.7	0.0	100.0	1,425
30-39	17.4	0.3	13.4	23.0	23.2	22.7	0.0	100.0	1,157
40-49	29.1	0.2	18.5	19.8	16.0	16.5	0.0	100.0	858
50+	44.8	0.5	26.3	13.8	9.4	5.1	0.0	100.0	768
Total	15.5	0.3	23.7	23.1	21.5	15.9	0.0	100.0	6,154

Contd.

Around nine-tenths of males as well as females in the age group of 7-9 had 1-5 years of schooling. About 23 percent of males have had education for 1-5 years. Females are also not far behind compared to their male counterparts in this category with a corresponding share of 20 percent. A slightly lesser proportion of females are found in higher education of 6-8 years, 9-10 years and 11 or more years (18 to 22 percent) compared to the males having corresponding figures (21 to 23 percent). Only 0.2 percent of the total population, 0.3 percent each of males and females are found to be literate without any formal schooling.

Table 2.3 EDUCATIONAL LEVEL OF THE HOUSEHOLD POPULATION								
Percent distribution of household population age 7 and above by literacy level and years of schooling, according to age, residence and sex, Andaman & Nicobar Islands, 2002-04								
Age	Non-literate	Literate but no schooling	Years of schooling				Total Percent	Number of persons
			1-5	6-8	9-10	11 or more		
URBAN								
Male								
7-9	8.3	2.1	89.7	0.0	0.0	0.0	100.0	84
10-14	2.0	0.0	50.9	39.5	7.5	0.0	100.0	180
15-19	3.9	0.0	4.2	26.3	37.1	28.5	100.0	181
20-29	2.1	0.0	2.3	17.6	35.4	42.6	100.0	329
30-39	5.2	0.0	8.6	15.3	27.9	43.0	100.0	335
40-49	9.8	0.0	14.4	19.8	25.7	30.3	100.0	201
50+	30.1	0.7	22.5	12.4	21.9	12.3	100.0	224
Total	8.4	0.2	18.9	19.3	25.5	27.7	100.0	1,533
Female								
7-9	15.8	0.0	84.2	0.0	0.0	0.0	100.0	64
10-14	0.0	0.0	43.5	47.0	9.5	0.0	100.0	146
15-19	1.1	0.0	4.0	16.7	39.6	38.5	100.0	182
20-29	8.6	0.0	6.1	13.0	25.4	46.9	100.0	410
30-39	15.0	0.0	10.4	16.7	25.0	32.9	100.0	254
40-49	30.6	0.0	15.9	22.7	16.3	14.5	100.0	168
50+	54.3	2.1	14.6	11.6	16.3	1.1	100.0	163
Total	16.2	0.2	16.3	18.2	22.2	26.8	100.0	1,387
Total								
7-9	11.5	1.2	87.3	0.0	0.0	0.0	100.0	147
10-14	1.1	0.0	47.6	42.9	8.4	0.0	100.0	326
15-19	2.5	0.0	4.1	21.5	38.4	33.5	100.0	363
20-29	5.7	0.0	4.4	15.0	29.9	45.0	100.0	739
30-39	9.5	0.0	9.4	15.9	26.6	38.6	100.0	589
40-49	19.3	0.0	15.1	21.1	21.4	23.1	100.0	369
50+	40.3	1.3	19.2	12.1	19.5	7.6	100.0	387
Total	12.1	0.2	17.7	18.7	23.9	27.3	100.0	2,920

An examination of the educational attainment by place of residence revealed that the urban-rural differential was not quite pronounced. In urban areas, about 12 percent of the total population is non-literate in comparison to 16 percent of the rural population. The numbers of non-literate females live in rural areas of Andaman & Nicobar Islands are accruing a share of 21 percent, while non-literate rural males are 11 percent. Prevalence of illiterates is less in urban areas with figures of 16 percent and 8 percent for females and males respectively. A contrasting feature of rural-urban difference in educational level is that in rural areas a significant proportion of people had 1-5 years of schooling (24 percent), and those who had 11 or more years of schooling was only 16 percent, whereas in urban areas a significant proportion of people had 11 or more years of schooling (27 percent) and those who had 1-5 years of schooling was only 18 percent.

2.4 Marital Status of the Household Population

The DLHS-RCH collected information on the marital status of all household members aged 10 years and above. Table 2.4 shows the percent distribution of household population by marital status distribution of *de facto* household population by age and sex. About 11 percent of females in the age group 15-19 years, followed by 57 percent in the age group 20-24 years, 87 percent in 25-29 years, and 92 percent in the age group 30-44 years, are currently married. The proportion of never married is 38 percent in the union territory and it is higher for males (42 percent) than for females (33 percent). The proportion of never married among males declines with increasing age and reaches the lowest by the time they are in the age group 30-44 years. The decline is much faster in the case of females. The proportions of divorced, separated or widowed are negligible and limited to the older ages. About 59 percent of women aged 60 years or above are widowed/divorced/separated. Among the *de facto* population aged 10 years and above, 56 percent of males and 60 percent of females are currently married.

Table 2.4 MARITAL STATUS OF THE HOUSEHOLD POPULATION						
Percent distribution of the household population aged 10 years and above by marital status, according to age and sex, Andaman & Nicobar Islands, 2002-04						
Age	Marital status				Total Percent	Number of persons
	Never married	Currently married	Married, gaunna not performed	Widowed/divorced/Separated		
Male						
10-14	100.0	0.0	0.0	0.0	100.0	554
15-19	99.5	0.5	0.0	0.0	100.0	601
20-24	86.8	13.2	0.0	0.0	100.0	446
25-29	44.4	55.6	0.0	0.1	100.0	500
30-44	6.1	92.8	0.0	1.1	100.0	1,240
45-59	1.2	96.2	0.0	2.6	100.0	717
60+	0.1	82.9	0.0	17.0	100.0	335
Total	42.0	56.0	0.0	2.0	100.0	4,393
Female						
10-14	100.0	0.0	0.0	0.0	100.0	546
15-19	89.2	10.8	0.0	0.0	100.0	502
20-24	42.9	56.5	0.0	0.6	100.0	638
25-29	10.8	87.1	0.0	2.1	100.0	581
30-44	2.5	92.4	0.0	5.1	100.0	1,050
45-59	0.8	85.2	0.0	14.0	100.0	567
60+	0.1	40.8	0.0	59.1	100.0	217
Total	33.2	60.0	0.0	6.8	100.0	4,101
Total						
10-14	100.0	0.0	0.0	0.0	100.0	1,100
15-19	94.8	5.2	0.0	0.0	100.0	1,103
20-24	61.0	38.6	0.0	0.4	100.0	1,084
25-29	26.3	72.5	0.0	1.2	100.0	1,081
30-44	4.5	92.6	0.0	2.9	100.0	2,290
45-59	1.0	91.4	0.0	7.6	100.0	1,284
60+	0.1	66.4	0.0	33.5	100.0	552
Total	37.8	57.9	0.0	4.3	100.0	8,494

Note: Table is based on de facto population.

2.5 Marriage

Marriage in the household is an important event that reflects the socio-cultural practices of the communities surveyed in DLHS. This section outlines the marriage ceremonies during the three years period prior to the survey. Mean age at marriage by sex and percentage of total marriages which are below legal age at marriage, 21 years for boys and 18 years for girls, by residence at the union territory and at district levels are shown in Table 2.5.

Table 2.5 MARRIAGE				
Mean age at marriage and percentage of marriages below legal age at marriage by sex and by districts, Andaman & Nicobar Islands, 2002-04				
Place of residence/ District	Mean age at marriage		Percentage of marriage below legal age at marriage	
	Boy	Girl	Boy (<21)	Girl (<18)
UT- Total	25.9	21.4	3.5	3.6
UT - Rural	25.7	20.9	3.8	5.3
UT - Urban	26.5	22.5	2.8	0.0
District				
Andamans	26.0	21.4	3.0	3.3
Nicobars	25.4	21.9	8.5	7.2

Note: Table based on de jure population. Reference period: - January 1st, 1999 to survey date for phase-1, and January 1st, 2001 to survey date for phase-2.

Mean ages at marriage for boys and girls in urban areas of Andaman & Nicobar Islands are 27 years and 23 years respectively. The corresponding figures in rural areas are 26 years and 21 years. On the whole, as far as Andaman & Nicobar Islands is concerned, both boys and girls seem to oblige the legal age at marriage, the average age at marriage being 26 years for boys and 21 years for girls. Only about 4 percent each of boys and girls got married below the corresponding specified legal age at marriage. The proportion is marginally higher in the rural areas compared to the urban areas of the union territory in the case of boys, while all the girls who got married below the specified legal age at marriage are from rural areas.

When it comes to district level variation in mean age at marriage, it is more or less the same in both the districts for boys as well as girls.

However, it is found that, the percentage of girls as well as boys who were married below the legal age at marriage was relatively higher in Nicobars district as compared to Andamans district.

2.6 Morbidity Rates

The DLHS-RCH has collected information on the morbidity status relating to blindness, tuberculosis and malaria of the *de jure* members of the household. Table 2.6 provides prevalence rates.

Table 2.6 MORBIDITY RATES			
Prevalence of blindness, tuberculosis, and malaria, according to place of residence, Andaman & Nicobar Islands, 2002-04.			
Morbidity	Total	Residence	
		Rural	Urban

Prevalence rate of blindness			
Male			
Partial	4,301	5,447	1,859
Complete	97	98	96
Night blindness	429	382	530
Female			
Partial	4,434	5,192	2,790
Complete	201	246	103
Night blindness	376	389	348
Persons			
Partial	4,366	5,323	2,306
Complete	147	169	99
Night blindness	403	385	443
Prevalence rate of tuberculosis			
Male	292	376	113
Female	225	225	225
Person	259	302	167
Prevalence rate of malaria¹			
Male	271	398	0
Female	132	136	123
Person	204	271	59
Note: All the rates refer to de jure population. Prevalence rate per 100, 000 population. Reference period: - January 1 st , 1999 to survey date for phase-1, and January 1 st , 2001 to survey date for phase-2. ¹ Last two weeks prior to the survey.			

Partial, Complete and Night Blindness

The overall prevalence of partial blindness is 4,366 per 100,000 population in the union territory and is lower in urban areas (2,306) than in rural areas (5,323). It is slightly more among females. The prevalence of complete blindness is 147 per 100,000 population with a rural-urban differential of 169 against 99 per 100,000. Sex differential in complete blindness is against females. The prevalence of night blindness due to vitamin A deficiency is 403 per 100,000 population, and is higher in urban areas (443) than in rural areas (385).

Tuberculosis

The prevalence of tuberculosis is 259 per 100,000 population, with rural areas having a relatively higher prevalence of 302 compared to 167 per 100,000 in urban areas. The prevalence of TB is higher among males (292 per 100,000) than among females (225 per 100,000).

Malaria

In the DLHS-RCH, household respondents were asked to union territory whether any member of their household suffered from malaria (characterized by recurrent fever with shivering) any time during the two weeks prior the survey. In the union territory of Andaman & Nicobar Islands, 204 persons per 100,000 population were reported to have suffered from malaria. Rural residents are more likely to suffer from malaria (271 per 100,000) than urban residents (59 per 100,000). The reported prevalence of malaria is higher for males than for females.

2.7 Morbidity Rates by Districts

Table 2.7 shows the prevalence of blindness, tuberculosis and malaria in the districts of Andaman & Nicobar Islands.

Table 2.7 MORBIDITY RATES BY DISTRICTS				
Prevalence of blindness, tuberculosis, and malaria, by district, Andaman & Nicobar Islands, 2002-04				
District	Prevalence ¹ of morbidity			
	Partial blindness	Complete blindness	Tuberculosis	Malaria ²
Andamans	4,651	127	247	132
Nicobars	2,480	280	341	678
Andaman & Nicobar Islands	4,366	147	259	204

Note: All the rates refer to de jure population. ¹ Prevalence rate per 100,000 population. Reference period: - January 1st, 1999 to survey date for phase-1, and January 1st, 2001 to survey date for phase-2. ² Last two weeks prior to the survey

The prevalence of partial blindness varies considerably in the two districts, it is 2,480 per 100,000 in Nicobars and 4,651 per 100,000 in Andamans district.

The prevalence rate of complete blindness is 127 per 100,000 in Andamans, while it is 280 per 100,000 in Nicobars district.

The prevalence rate of tuberculosis is higher in Nicobars (341 per 100,000 population) than in Andamans (247 per 100,000). In the case of malaria, the prevalence rate is much higher in Nicobars (678 per 100,000) than in Andamans (132 per 100,000).

2.8 Housing Characteristics

This section describes the availability of basic amenities in the union territory. Table 2.8 presents the percent distribution of households by selected housing characteristics. About 87 percent of the households in Andaman & Nicobar Islands have electricity connection and it is much higher in urban areas (99 percent) than in rural areas (82 percent).

As regards household source of drinking water, about 87 percent of the households get drinking water through taps either inside or shared public, while 12 percent drink water from wells either covered or uncovered. All the households in urban areas get piped water for drinking, whereas in rural areas about four-fifths of the households have such provision.

Table 2.8 HOUSING CHARACTERISTICS		
Percent distribution of the households by housing characteristics and percentage of households owing selected durable goods, according to residence, Andaman & Nicobar Islands, 2002-04		
Housing characteristic	Total	Residence

		Rural	Urban
Electricity			
Yes	87.2	81.6	98.5
No	12.8	18.4	1.5
Source of drinking water			
Tap inside	57.3	41.1	90.1
Tap shared public	29.3	38.8	9.9
Hand pump/ bore well	0.1	0.2	0.0
Well covered	2.3	3.4	0.0
Well uncovered	9.7	14.5	0.0
River	0.4	0.6	0.0
Pond	0.6	0.9	0.0
Spring	0.1	0.1	0.0
Other	0.3	0.4	0.0
Sanitation facility			
Own flush toilet	59.1	45.9	85.7
Own pit toilet / latrine	6.3	8.5	1.8
Shared toilet of any type	2.9	2.7	3.2
Public / community toilet	1.4	0.5	3.1
No toilet facility	30.4	42.4	6.2
Main type of fuel used for cooking			
Liquid petroleum gas/electricity	41.8	25.8	74.1
Kerosene	19.6	18.2	22.5
Wood	38.3	55.5	3.4
Other	0.3	0.5	0.0
Type of house			
Kachcha	27.2	38.8	3.6
Semi - pucca	22.2	22.5	21.5
Pucca	50.7	38.7	75.0
Household assets			
Fan	80.2	71.8	97.3
Radio/transistor	62.4	58.2	71.1
Sewing machine	24.4	21.8	29.7
Television	70.5	60.5	90.9
Telephone	38.8	29.2	58.1
Bicycle	33.1	44.0	11.0
Motor cycle/ scooter	25.5	18.6	39.4
Car / Jeep	2.8	1.8	4.7
Tractor	0.8	1.0	0.5
Standard of living index			
Low	19.0	27.8	1.2
Medium	30.5	35.7	20.1
High	50.5	36.5	78.7
Number of households	2,175	1,458	717

When it comes to sanitation facility, about 59 percent of the households have flush toilets, while 6 percent have pit based toilets or latrines, 3 percent depend on shared toilets and nearly 30 percent of the households have no toilet facility at all. There is a large rural-urban difference; 42 percent of rural households have no toilet facility, compared to just 6 percent of urban households.

DLHS-RCH has also collected data on type of fuel used in the households for cooking. About 42 percent of the households used liquid petroleum gas or electricity for cooking in Andaman & Nicobar Islands. About 38 percent of households rely on fire woods, and 20 percent

on kerosene. The use of liquid petroleum gas/electricity for cooking is reported more in urban areas (74 percent), and firewood for cooking is reported more in rural areas (56 percent).

There is considerable variation in the quality of housing. On the basis of building material, type of floor, walls and roof, households are categorised into *kachcha*, *semi-pucca* and *pucca*. A little more than one-fourth of the households are living in *kachcha* houses, 22 percent in semi *pucca* houses and 51 percent in *pucca* houses. Seventy-five percent of urban households live in *pucca* houses compared to 39 percent of rural households.

The possession of consumer durable goods is an indication of a household's socio-economic status. Table 2.8 shows that majority of the households in the union territory own fan (80 percent), television (70 percent) and radio/transistor (62 percent), while a significant proportion own telephone (39 percent) and bicycle (33 percent). Other durable goods found in the surveyed households are motorcycle or scooter (26 percent) and sewing machine (24 percent). Car/jeep is owned by 3 percent of households and tractor is owned by less than one percent in Andaman & Nicobar Islands. Ownership of these consumer durable items is more among the urban households than among the rural households, exception being bicycle.

Considering household amenities, such as, source of drinking water, type of house, source of lighting, fuel for cooking, toilet facility and ownership of durable goods, a composite measure, standard of living index (SLI) is developed for classification of households. The standard of living index is calculated by adding the following scores:

Source of drinking water: 3 for Tap (own), 2 for Tap (shared), 1 for hand pump and well, and 0 for other;

Type of house: 4 for *pucca*, 2 for semi-*pucca*, and 0 for *kachcha*;

Source of lighting: 2 for electricity, 1 for kerosene, and 0 for other;

Fuel for cooking: 2 for LPG gas/electricity, 1 for kerosene and 0 for other;

Toilet facility: 4 for own flush toilet, 2 for own pit toilet, 2 for shared toilet and 0 for no toilet;

Ownership for items: 4 each for car and tractor, 3 each for television, telephone and motorcycle/scooter, and 2 each for fan, radio/transistor, sewing machine and bicycle.

The total of the scores may vary from the lowest of 0 to a maximum of 40. On the basis of total score, households are divided into three categories as;

- a) Low – if total score is less than or equal to 9,
- b) Medium – if total score is greater than 9 but less than or equal to 19 and
- c) High – if total score is greater than 19.

As per the standard of living index, about one-fifth of the households come under the low standard of living category (19 percent) and one-third come under the medium standard of living category (31 percent), while half of the households (51 percent) have a high standard of living.

The proportion of sample households with a high standard of living is much higher in urban areas (79 percent) than in rural areas (37 percent), while the proportion of households with a low standard of living is much higher in rural households (28 percent) than in urban households (1 percent) in the union territory of Andaman & Nicobar Islands.

2.9 Housing Characteristics by Districts

The two districts in Andaman & Nicobar Islands are not uniform in terms of basic amenities and possession of consumer durables. Table 2.9 presents a district-wise comparison of housing characteristics. The percentage of households with electricity is more than 80 percent in the two districts. The proportion of households with electricity is comparatively higher in Andamans (88 percent). More than nine-tenths of households used piped water or water from a hand pump for drinking in Andamans (93 percent), while it is only 62 percent in Nicobars district.

The Nicobars district in Andaman & Nicobar Islands has inadequate toilet facility, with about 47 percent of the households have toilet facilities, while it is 73 percent in Andamans district.

In Andamans district the proportion of households using liquid petroleum gas/electricity for cooking is 45 percent and in Nicobars district, it is much lower at 21 percent. The percentage of households living in *pucca* houses is much lower in Nicobars district (26 percent) of Andaman & Nicobar Islands as compared to Andamans district where more than half of the households (54 percent) live in *pucca* houses.

Table 2.9 HOUSING CHARACTERISTICS BY DISTRICT					
Selected housing characteristics by district, Andaman & Nicobar Islands, 2002-04					
Districts	Percentage of households:				
	With electricity	With drinking water ¹	With toilet facility	Using Liquid petroleum gas/ electricity	Living in pucca house
Andamans	88.0	92.6	72.6	44.6	53.9
Nicobars	81.0	61.5	46.9	20.5	26.2
Andaman & Nicobar Islands	87.2	88.9	69.6	41.8	50.7

Note: ¹ That is piped or from a hand pump/bore well.

2.10 Iodization of Salt

Consumption of salt fortified with iodine is recommended to avoid miscarriages, brain disorders, cretinism and retarded psychomotor development. As per the Prevention of Food Adulteration Act, 1988, the minimum iodine content of edible salt is 30 parts per million (PPM) at the manufacturing level.

In the DLHS-RCH survey, each interviewer was provided with a test kit to measure the level of iodine content of salt consumed by the surveyed households. The test results (Table 2.10) are classified by degree of iodization of salt and categorised by background characteristics. It is observed that as high as 95 percent of households used salt that contained a minimum recommended 15 ppm or higher level of iodine content, whereas a negligible percent of households used salt that is not iodized at all and another 3 percent used salt, which was inadequately iodized.

Table 2.10 IODIZATION OF SALT						
Percent distribution of household heads by degree of iodization of salt, according to selected background characteristics, Andaman and Nicobar Islands, 2002-04						
Background characteristic	Not	7ppm	15+ppm	Other ¹	Total	Number

	Iodised			percent of households		
Place of Residence						
Rural	0.3	4.4	94.6	0.7	100.0	1,458
Urban	0.0	1.2	96.2	2.6	100.0	717
Education of the household heads						
Non-literate	0.6	5.5	92.5	1.5	100.0	466
0-9@ years	0.1	3.3	95.7	0.9	100.0	1,008
10 and above	0.2	2.0	96.0	1.8	100.0	701
Religion of household head						
Hindu	0.2	1.9	96.5	1.4	100.0	1,465
Muslim	0.5	2.6	95.5	1.4	100.0	209
Christian	0.2	7.9	91.2	0.7	100.0	481
Other	(0.0)	(3.4)	(89.7)	(6.9)	(100.0)	20
Caste/tribe of the household head#						
Scheduled caste	0.6	8.5	89.8	1.1	100.0	197
Scheduled tribe	0.2	7.6	91.2	1.0	100.0	180
Other backward class	(0.0)	(6.0)	(92.5)	(1.5)	(100.0)	46
Other	0.1	2.0	96.5	1.4	100.0	1,520
Standard of living index						
Low	0.8	3.4	95.3	0.5	100.0	414
Medium	0.0	5.6	93.2	1.2	100.0	664
High	0.1	2.0	96.2	1.7	100.0	1,097
Total	0.2	3.4	95.1	1.3	100.0	2,175
Note: Ppm: Parts per million. @ Literate persons with no years of schooling are also included. # Total number of cases may not add upto N due to do not know and missing cases. ¹ Includes salt not at home, salt not tested, refused and missing cases. () Based on less than 50 unweighted cases						

All the households who reported the use of non-iodized salts are from rural areas. Percentage of households using inadequately iodized salt in rural areas is slightly higher compared to that in urban areas. A slightly higher proportion of households headed by illiterate persons reported using non-iodized or inadequately iodized salt. Nearly 96 percent of households headed by persons who are literate reported the use of adequately iodized salts. Consumption of adequately iodised salt among households of other castes is 97 percent, followed by 92 percent in other backward class households and among scheduled castes and scheduled tribes it is 90 and 91 percent of households respectively.

Differential in the consumption of properly iodized salt is also not much when analysed by religion of the household head and standard of living index. Proportion of households using adequately iodized salt is 91 percent among Christian households, whereas the corresponding figures for Hindu and Muslim households are 97 percent and 96 percent respectively. There is not much variation in the proportion of households using adequately iodized salt by standard of living.

2.11 Iodization of Salt by Districts

Table 2.11 shows district level variation in the percent distribution of households by level of iodization of salt used in the households. Proportion of households using inadequately iodized salt is higher in Nicobars (9 percent) than in Andamans (3 percent). Around 95 percent of the households in the union territory used adequately iodized salt, it is being higher in the district of Andamans (96 percent) than in Nicobars (89 percent).

Table 2.11 IDOIZATION OF SALT BY DISTRICTS				
Percent distribution of household heads by degree of idoization of salt by district, Andaman & Nicobar Islands, 2002-04				
District	Not idoized	7ppm	15+ppm	Other ¹
Andamans	0.2	2.6	95.9	1.4
Nicobars	0.5	9.2	89.3	1.0
Andaman & Nicobar Islands	0.2	3.4	95.1	1.3
Note: Ppm: Parts per million. ¹ Includes salt not at home, salt not tested, refused and missing cases.				

2.12 Availability of Facility and Services to the Rural Population

The DLHS-RCH collected information about surveyed villages from knowledgeable persons such as, the ‘Sarpanch’ or ‘Pradhan’, (village head) or other village officials or other persons including ‘teacher’ in the villages on health and educational facilities and other services available in the villages. One important aspect was on the distance of the village, if not available within the village, from various types of education facilities, including primary school, middle school, secondary school, higher secondary school, college, *Gurujee* scheme and ‘*Madarsa*’. Further information on the distance of the village, if not available within the village, from various types of health facility, including sub-centres, primary health centres (PHCs), community health centres/ Rural Hospitals (CHCs/RHs), Government dispensary, hospital, private clinic or hospitals and health facilities of Indian system of Medicine (ISM).

Table 2.12 gives the distance of surveyed villages from an education facility. The unit of analysis is usual residents of rural population. Majority of the rural residents (68 percent) (the *de jure* rural population) in the union territory live in villages that have a primary school, 47 percent live in villages with middle school and 24 percent of the rural population live in villages with secondary schools. Higher secondary schools are available for 31 percent of the rural population. About 9 percent of the rural population live in villages, which have *Madarassas*, while 14 percent of villages have a *Gurujee* scheme. Only 9 percent of the surveyed villages have a college. As regards the distribution of educational institutions within 5 kilometres distance from of the village, it can be seen that 22 percent of the villages have secondary school, 20 percent have middle school, and 14 percent each have higher secondary school or primary school within this distance. For 17 percent of the villages, the college is more than 10 kilometres away, 23 percent of the villages have higher secondary school at this distance and Secondary schools are available at this distance for 21 percent of the villages.

Table 2.12 DISTANCE FROM THE NEAREST EDUCATION FACILITY						
Percent distribution of rural household population by distance from the nearest education facility, Andaman & Nicobar Islands, 2002-04						
Education facility	Within village	Distance from the village:			Don't know/missing	Total percent
		< 5 km	5-9 km	10+ km		
Primary School	68.2	13.9	15.1	0.0	2.8	100.0
Middle School	47.4	19.7	25.9	1.9	5.0	100.0
Secondary School	24.0	21.8	14.1	20.6	19.5	100.0
Higher Secondary School	30.9	13.7	20.9	23.0	11.5	100.0
College	9.2	0.0	13.1	17.2	60.6	100.0
Gurujee Scheme	13.6	0.0	0.0	0.0	86.4	100.0
Madarsa	9.2	4.5	2.7	0.0	83.7	100.0

Note: Table based on rural de jure population.

Table 2.13 summarises the availability of health facilities within the surveyed villages and provides information on the distance between the villages and the nearest health facility. About 56 percent of the rural population live in villages with Sub-centres. Only 30 percent of the rural household population live in a village with a primary health centre, though the proportion of villages having facilities of either Sub-centre or primary health centre is 68 percent. The proportion of rural population with other health facilities are 15 percent for CHCs/RHs, 7 percent for Government dispensary, 15 percent for Government hospitals, 9 percent for private clinics, 5 percent for private hospitals and 4 percent for Indian System of Medicine.

Table 2.13 DISTANCE FROM THE NEAREST HEALTH FACILITY						
Percent distribution of rural household population by distance from the nearest health facility, Andaman & Nicobar Islands, 2002-04						
Health facility	Within village	Distance from the village:			Don't know/missing	Total percent
		< 5 km	5-9 km	10+ km		
Rural household population						
Sub-centre	55.9	17.2	7.6	2.5	16.9	100.0
Primary health centre	30.4	11.4	25.6	18.8	13.8	100.0
Either sub-centre or PHC	68.4	14.7	5.4	2.5	9.1	100.0
Community health centre/Referral hospital	15.4	4.5	20.6	31.1	28.3	100.0
Government dispensary	6.8	0.0	4.8	15.1	73.3	100.0
Government hospital	15.3	0.0	10.8	32.2	41.6	100.0
Private clinic	8.8	4.4	4.3	5.1	77.4	100.0
Private hospital	4.5	0.0	4.3	5.1	86.2	100.0
ISM health facility	4.0	6.6	9.8	11.8	67.8	100.0

Note: Table based on rural de jure population.

The proportion of rural population located within a distance of 5 kilometres from health facilities are 17 percent for sub-centres, 11 percent for primary health centres, 5 percent for CHCs/RHs, 4 percent for private clinics and 7 percent for ISM health facilities. Distance of particular health facility is beyond 10 kilometres from surveyed villages in the case of Government hospitals (32 percent) and for CHCs/RHs (31 percent).

Table 2.14 shows the proportion of rural residents in the union territory that live in the villages with various health services. Almost 80 percent of rural residents live in villages that have an *anganwadi*, a nursery school for children age 3-6 years and at the same time 89 percent of rural households live in villages with *anganwadi* workers (*Anganwadi* workers provide integrated child development services).

Table 2.14 AVAILABILITY OF SERVICES	
Percentage of rural residents living in villages that have sleeted services, Andaman & Nicobar Islands, 2002-04	
Services	Percentage of rural residents
Anganwadi centre	80.4
Anganwadi worker	88.8
Private doctor	18.0
Visiting doctor	22.2
Homeopathic doctor	20.5
Village health guide	30.3
Trained birth attendant	43.9
Traditional healer	40.2
Dai	70.1

Note: Table based on rural de jure population.

Eighteen percent of the rural residents live in villages that have a private doctor, 22 percent with a visiting doctor, 21 percent with a homeopathy doctor, 30 percent with a village health guide, 44 percent with a trained birth attendant and 40 percent with a traditional healer. Majority of the rural residents (70 percent) live in villages that have a *Dai* (*Dai* provides the services for the delivery).

2.13 Availability of Education Facility and Health Services by Districts

Table 2.15 shows the availability of education and health facilities for the rural population within the surveyed villages by districts in Andaman & Nicobar Islands. In the district of Nicobars, more than nine-tenths of the rural population have access to primary or middle schools. In the union territory of Andaman & Nicobar Islands, 71 percent of the rural population live in villages having primary schools. Around 56 percent of the rural population in the union territory have sub-centres within the village, with more coverage of 76 percent in Nicobars, while it is 51 percent of the population in Andamans.

Table 2.15 AVAILABILITY OF FACILITY AND SERVICES BY DISTRICT							
Selected facility and services of rural household population within village by district, Andaman & Nicobar Islands, 2002-04							
Districts	Percentage of rural household population with:						
	Primary or middle school	Sub-centre	PHCs	Any government health facility ¹	Doctor ²	TBA ³	Anganwadi worker
Andamans	66.0	51.0	33.2	69.2	37.7	40.5	87.7
Nicobars	91.7	76.4	18.8	79.9	28.3	58.4	93.4
Andaman & Nicobar Islands	70.9	55.9	30.4	71.3	35.9	43.9	88.8

Note: ¹ Includes sub-center, primary health center, community health center or referral hospital, government hospital, and government dispensary within the village ² Either private or visiting doctor ³ Trained birth attendant.

The availability of PHCs within the village is found to be relatively more in Andamans (33 percent). More than three-fourths of the households in the rural areas of Nicobars and 69 percent in Andamans have access to at least one government health facility including sub-centre, primary health centre, community health centre or referral hospital, government hospital and government dispensary within the village.

Around 38 percent of the rural population in Andamans and 28 percent in Nicobars are visited either by private or by visiting doctors in the surveyed villages. More numbers of rural population (58 percent) are attended by trained birth attendants in Nicobars, while 41 percent of rural population availed themselves of such a provision in Andamans. A visit by *anganwadi* workers is reported by a majority of the rural households in Nicobars (93 percent) and Andamans (88 percent).

CHAPTER III

CHARACTERISTICS OF WOMEN, HUSBANDS AND FERTILITY

The Reproductive and Child Health (RCH) programme is targeted towards the underprivileged sections of the population, particularly, women and children. The utilization of RCH services being provided across the country depends to a large extent on the characteristics of women, their husbands and episodes of pregnancies, miscarriages, abortions, number of children born to them and survival status of children. Age of women, marital duration, educational attainment, social background and living standard are important factors, which influence reproductive and child health. With this in view, the DLHS-RCH data were collected on demographic characteristics, such as current age, age at consummation of marriage and number of pregnancies, live births and surviving children from eligible women respondents of selected representative households. Information regarding household background characteristics was collected using a separate household questionnaire that covered religion and caste of head of household, type of house, source of drinking water and possession of consumer durables. Fertility preferences of women in terms of timing and desire for additional children in comparison to the number of living children provides information on the need for reproductive and child health services.

This chapter provides a comprehensive outline of distribution of currently married women by present age, age at consummation of marriage, duration of marriage, completed years of schooling, pregnancy episodes, children ever born and children surviving, along with social and economic characteristics of households the women represent.

3.1 Background Characteristics of Women

The percent distribution of currently married women in the reproductive age group 15-44 years by residence, religion and caste of head of household, economic standard of household, education and other demographic characteristics are shown in Table 3.1. A sample of 1,782 eligible women represents the union territory of Andaman & Nicobar Islands in DLHS-RCH and more than four-fifths of these women are drawn from rural areas. About 68 percent of the currently married women are in the age range of 20-34 years and a similar age distribution is observed both for rural and urban areas. Age at consummation of marriage, in both rural and urban areas, is found to be high with as many as 72 to 74 percent of the women having cohabited before 18 years of age. Looking at the distribution of marital duration, it is noted that about 30 percent of the women across the union territory are married for more than 15 years.

Among the sample of 1,782 representative women in Andaman & Nicobar Islands, Hindus, Muslims and Christians constitute 51 percent, 8 percent and 40 percent respectively. More Hindu women are found in urban areas (69 percent) than in rural areas (48 percent). The presence of women belonging to other religious groups is very insignificant in proportional and

absolute terms. About 11 percent of the women belong to scheduled castes, 29 percent to scheduled tribes and 2 percent to other backward classes. Around 52 percent of the sample women belong to a general caste other than scheduled caste/tribe and other backward class. In rural areas, there are more women belonging to scheduled caste and scheduled tribe than in urban areas, while more women from other castes are found in urban areas. There is a rural-urban differential in the educational attainment of women. For the union territory of Andaman & Nicobar Islands, 22 percent of women are non-literate and women of this literacy category constitute 24 percent in rural areas, while it is 13 percent in urban areas.

Table 3.1 BACKGROUND CHARACTERISTICS OF WOMEN			
Percent distribution of currently married women aged 15-44 by selected background characteristics, according to residence, Andaman & Nicobar Islands, 2002-04			
Background characteristic	Total	Residence	
		Rural	Urban
Age group			
15-19	2.7	2.7	2.5
20-24	16.8	15.6	22.5
25-29	29.8	30.2	28.1
30-34	21.5	21.7	20.5
35-39	16.8	16.2	19.4
40-44	12.4	13.5	7.0
Age at consummation of marriage			
Below 18 years	26.1	25.8	27.6
18 years & above	73.9	74.2	72.4
Marital duration			
0-4	22.6	22.6	22.6
5-9	24.8	24.3	26.8
10-14	22.9	23.0	22.7
15+	29.7	30.1	27.8
Religion			
Hindu	51.3	47.5	69.3
Muslim	7.7	5.0	20.2
Christian	39.5	46.0	9.4
Sikh	1.4	1.5	0.9
Buddhist	0.1	0.0	0.3
Caste/tribe			
Scheduled caste	10.5	12.3	2.1
Scheduled tribe	29.0	35.0	0.9
Other backward class	2.1	2.4	0.9
Other #	51.9	44.3	87.6
Don't know	6.4	6.0	8.4
Education (Years of schooling)			
Non-literate	22.0	24.0	12.6
0-9@ years	48.6	50.3	40.6
10 years & above	29.4	25.7	46.8
Husband's education (Years of schooling)			
Non-literate	15.1	16.5	8.4
0-9@ years	47.1	49.5	36.2
10 years & above	37.8	34.0	55.4
Don't know	0.0	0.1	0.0
Standard of living index			
Low	24.1	29.0	1.2
Medium	35.3	38.5	20.2
High	40.6	32.5	78.6
Number of women	1,782	1,467	315

Note: # Not belonging to a scheduled caste, scheduled tribe and an other backward class. @ Literate persons with no year of schooling are included.

Around 49 percent of women in the union territory have completed 0-9 years of schooling. Only 26 percent of rural women have completed 10 or more years of schooling compared to 47 percent for urban women. Men are more literate than their spouses. In Andaman & Nicobar Islands, 15 percent of the husbands of eligible women are non-literate and the corresponding figures are 17 percent in rural areas and 8 percent in urban areas. The DLHS-RCH includes data on materials used for floor, walls and roofs of the housing structure along with status of possession of a list of durables and these are utilized to construct a composite index of household standard of living. Households are further classified as those with low, medium and high standard of living. Around 24 percent of women in the union territory live in low standard of living households and this is 29 percent in rural areas and one percent in urban areas. A little more than one-third of women across the union territory live in households categorised as medium standard of living. In urban areas, 79 percent of women belong to high standard of living households and the corresponding figure is 33 percent in rural areas.

3.2 Educational Level of Women

Table 3.2 provides details of educational level of eligible women in terms of classification by years of schooling, and selected background characteristics, such as, place of residence, religion, and caste and husbands' education. As regards distribution of non-literate women, it is observed that a lesser proportion of younger women below 30 years of age are non-literate compared to older women above 30 years. This age divide remains true even among literate women. A distinct pattern of educational attainment of women is that a sizeable proportion of them attended schooling for 6-8 years or 9-10 years or 11 or more years of schooling. For the women in the age group 15-24 years, 25 percent and 31 percent of them had 6-8 years and 9-10 years of schooling, while only 15 percent each had 1-5 years and 11 or more years of schooling. Among the senior women in the age group 40-44 years, a lower proportion of them had 9-10 and 11 or more years of schooling.

There is a significant rural-urban differential in the level of education of women in Andaman & Nicobar Islands. About 24 percent of rural eligible women are non-literate and 14 percent, 22 percent, 24 percent and 16 percent of the women have 1-5, 6-8, 9-10 and 11 or more years of schooling. The corresponding figures in urban areas are 13 percent for non-literate and 11 percent, 17 percent, 28 percent and 32 percent for literate categories. More Christian women (31 percent) and Hindu women (18 percent) are non-literate compared to Muslim women (4 percent). For literate eligible women from all religious communities, there is no clear trend in the years of schooling categories. The proportion of Hindu women with 1-5 years of schooling is 15 percent and the same is 17 percent for Muslim women and 12 percent for Christian women. Among the literate Muslim women, 26 percent of them have 11 or more years of schooling and 23 percent of literate Hindu women have attained this level of education, while it is only 11 percent among the literate Christian women.

The uneven level of educational attainment by caste can be noted from the recorded proportion of non-literate women among scheduled caste (22 percent), scheduled tribe (35 percent), other backward class (18 percent) and other caste or tribe (15 percent). The literate women belonging to scheduled castes or tribes are concentrated more in the range of 6-8 and 9-10 years of schooling. The husbands' education is an important characteristic, which has strong association with the education of eligible women. As many as 62 percent of women whose husbands are non-literate are also non-literate, while only 4 percent of women whose husbands have 11 or more or years of schooling are non-literate. About 54 percent of literate women educated for 11 or more years of schooling have husbands who have the same level of education.

Table 3.2 LEVEL OF EDUCATION OF ELIGIBLE WOMEN								
Percent distribution of currently married women aged 15-44 by years of schooling, according to selected background characteristics, Andaman & Nicobar Islands, 2002-04								
Background characteristic	Non-literate	Literate but no schooling	Years of schooling				Total percent	Number of women
			1-5 years	6-8 years	9-10 years	11 or more years		
Age group								
< 25	13.7	0.0	15.3	25.1	30.5	15.5	100.0	348
25-29	12.3	0.0	13.6	17.8	29.4	26.9	100.0	531
30-34	26.4	0.0	8.0	19.7	27.1	18.7	100.0	383
35-39	32.5	0.0	15.2	21.1	16.5	14.7	100.0	299
40-44	36.6	0.4	17.3	21.9	12.1	11.7	100.0	220
Place of residence								
Rural	24.0	0.1	14.0	21.5	24.2	16.3	100.0	1,467
Urban	12.6	0.0	11.2	16.8	27.9	31.5	100.0	315
Religion								
Hindu	17.9	0.0	14.5	21.1	23.4	23.2	100.0	915
Muslim	4.0	0.0	16.5	18.2	35.1	26.2	100.0	138
Christian	31.2	0.1	11.7	21.0	24.6	11.4	100.0	704
Other	(8.3)	(0.0)	(8.3)	(12.5)	(25.0)	(45.8)	(100.0)	26
Caste/tribe #								
Scheduled caste	21.5	0.0	6.7	21.1	31.6	19.1	100.0	187
Scheduled tribe	35.3	0.2	13.1	19.1	22.4	9.8	100.0	517
Other backward class	(18.0)	(0.0)	(22.0)	(16.0)	(24.0)	(20.0)	(100.0)	38
Other	15.4	0.0	14.8	20.9	24.8	24.1	100.0	925
Husband's education								
Non-literate	61.5	0.0	14.6	12.3	7.7	3.9	100.0	268
1-5 years	33.0	0.0	28.9	22.2	13.2	2.7	100.0	249
6-8 years	20.4	0.0	18.8	30.5	24.1	6.2	100.0	378
9-10 years	12.0	0.0	8.5	23.8	39.7	16.0	100.0	466
11 or more years	2.7	0.2	3.9	12.7	26.9	53.5	100.0	418
Total	22.0	0.1	13.5	20.7	24.8	19.0	100.0	1,782
Note: Total includes 3 cases and 1 case in Literate but no schooling and do not know case respectively on husband's education who were not shown separately. # Total number may not add upto N due to don't know and missing cases. () based on less than 50 unweighted cases.								

3.3 Background Characteristics of Husbands of Eligible Women

In DLHS-RCH, husbands of eligible women were also interviewed. The response rate for husbands is relatively low compared to that of eligible women. Selected background characteristics of husbands are shown in Table 3.3. Across the union territory of Andaman &

Nicobar Islands, husbands are mostly in the age group 25-44 years. Fewer husbands are 24 years or younger. In Andaman & Nicobar Islands, 69 percent of the husbands are Hindus, 10 percent are Muslims and 21 percent are Christians. Around 8 percent of husbands each in the union territory belong to the scheduled caste and scheduled tribe and these proportions are relatively more in rural areas than in urban areas. Sixty-nine percent of the husbands belong to castes other than scheduled caste, scheduled tribe and other backward classes. In urban areas husbands from other castes constitute 86 percent, while it is 62 percent in rural areas. As regards educational characteristics of the husbands of surveyed eligible women, two-fifths of them have completed 10 or more years of schooling and the proportion of non-literate husbands ranges from 8 percent in urban areas to 13 percent in rural areas, while the overall union territory figure is 11 percent.

Table 3.3 BACKGROUND CHARACTERISTICS OF MEN			
Percent distribution of husbands of eligible women by selected background characteristics, according to residence, Andaman & Nicobar Islands, 2002-04			
Background characteristic	Total	Residence	
		Rural	Urban
Age group			
< 25	2.7	2.9	2.2
25-34	37.4	36.4	39.8
35-44	40.9	38.5	46.9
45 +	19.0	22.1	11.1
Religion			
Hindu	68.5	69.0	67.0
Muslim	10.3	5.9	21.4
Christian	20.8	24.7	11.0
Sikh	0.5	0.4	0.5
Caste/tribe			
Scheduled caste	8.3	10.4	2.9
Scheduled tribe	8.2	10.9	1.1
Other backward class	1.8	2.1	1.0
Other #	69.0	62.2	86.3
Don't know	12.7	14.3	8.6
Education (Years of schooling)			
Non-literate			
0-9@ years	11.4	12.7	8.1
10 years & above	47.9	52.2	36.9
	40.7	35.0	55.0
Standard of living index			
Low	20.4	28.2	0.8
Medium	31.1	36.1	18.5
High	48.4	35.7	80.8
Number of living children			
0	8.8	7.9	11.3
1	24.0	25.2	20.9
2	37.0	35.3	41.2
3	19.4	20.7	16.2
4+	10.8	10.9	10.4
Number of Men	1,140	817	323

Note: # Not belonging to a scheduled caste, scheduled tribe and other backward classes. @ Literate persons with no year of schooling are included.

The proportion of husbands living in households classified as low, medium and high standard of living index are 20 percent, 31 percent and 48 percent respectively. In rural areas, 28 percent of the husbands live in low standard of living households compared to less than one percent in urban areas. This is complementary in the case of husbands living in high standard of living households, 81 percent in urban and 36 percent in rural. In terms of household standard of living composition, those living in medium standard of living is more in rural (36 percent) than in urban (19 percent) Andaman & Nicobar Islands. Thirty-seven percent of husbands across the union territory reported to have two living children. More husbands in urban areas (41 percent) as well as in rural areas (35 percent) have two living children. About 32 percent of the husbands of rural eligible women have more than three living children and it is 27 percent for husbands of urban eligible women.

3.4 Educational Level of Husbands of Eligible Women

Educational levels in categories of years of schooling classified by age, place of residence, religion and caste/tribe of husbands of eligible women are shown in Table 3.4. The distribution of non-literate husbands across age is not uniform and it is comparatively more for husbands aged 45 years or older (17 percent) than those who are below 35 years (10 percent). Among the literate husbands, irrespective of their age at the time of survey a majority of them have 1-10 years of schooling, around three-fourths of those below 25 years and three-fifths of those above 45 years of age. As expected few of the younger husbands below 25 years (11 percent) have 11 or more years of schooling and the proportion of the husbands having 11 or more years of schooling is more among those aged 25-34 years and 35-44 years (each 31 percent) compared to 20 percent of those above 45 years. As in the case of eligible women, 3 percent of Muslim husbands are non-literate while the corresponding non-literate husbands of Hindu and Christian religions are 9 percent and 21 percent respectively. The proportions of husbands of Hindu, Muslim and Christian religions who have 11 or more years of schooling constitute 30 percent, 27 percent and 25 percent respectively. A majority of the literate Muslim husbands (71 percent) have completed 1-10 years of schooling and the corresponding numbers are 60 percent and 50 percent respectively for Hindu and Christian religion husbands. Educational attainment of husbands of eligible women varies according to the caste/tribe they belong. There are relatively more non-literate husbands belonging to scheduled tribes (21 percent) followed by husbands belonging to other caste/tribe (10 percent) and scheduled caste husbands (9 percent). Among the scheduled caste and scheduled tribe husbands, 24 percent and 12 percent of them have 11 or more years of schooling.

Table 3.4 LEVEL OF EDUCATION OF MEN

Percent distribution of husbands of eligible women by years of schooling, according to selected background characteristics, Andaman & Nicobar Islands, 2002-04

Background characteristics	Non-literate	Literate but no schooling	Years of schooling				Total percent	Number of men
			1-5 years	6-8 years	9-10 years	11 or more years		
Age group								
< 25	(11.1)	(0.0)	(8.3)	(30.6)	(38.9)	(11.1)	(100.0)	31
25-34	9.4	0.3	10.4	26.6	22.7	30.5	100.0	426
35-44	10.9	0.3	16.6	16.5	24.5	31.2	100.0	466
45+	16.9	2.9	26.1	16.5	18.1	19.5	100.0	216
Place of residence								
Rural	12.7	1.1	17.8	23.0	18.8	26.5	100.0	817
Urban	8.1	0.0	11.3	15.0	32.4	33.3	100.0	323
Religion								
Hindu	9.4	0.3	19.5	19.2	21.7	29.9	100.0	780
Muslim	2.5	0.0	13.0	28.6	29.2	26.7	100.0	117
Christian	22.8	2.6	5.7	22.3	21.9	24.7	100.0	237
Caste/tribe #								
Scheduled caste	8.7	0.0	46.1	11.3	9.8	24.0	100.0	95
Scheduled tribe	20.9	0.0	12.9	24.3	30.1	11.8	100.0	93
Other	9.6	1.1	12.3	18.7	25.0	33.3	100.0	787
Total	11.4	0.8	15.9	20.7	22.7	28.5	100.0	1,140

Note: Total includes 5 cases in religion-other, 21 cases in caste/tribe-other backward class were not shown separately. # Total number may not add upto N due to don't know and missing cases. () based on less than 50 unweighted cases.

3.5 Children Ever Born and Surviving

In DLHS-RCH, currently married women in the age group of 15-44 years were asked about the children born alive and the number of children surviving. Table 3.5 shows mean children ever born and mean surviving children by selected background characteristics and sex of children. A look at the mean children ever born by age of the women reveals that older women had experienced more average live births than younger women. On the average, women in the reproductive age group have given birth to slightly more male children than female children and a similar sex differential is also noted when it comes to mean surviving children. Completed fertility, that is, mean children ever born to women in the age group 40-44 years is 2.8 for the union territory of Andaman & Nicobar Islands and it comprises an average of 1.6 male children and 1.2 female children. Out of the 2.8 mean children ever born to women in the 40-44 year age group, all the children were reported to be survived.

Table 3.5 CHILDREN EVER BORN AND LIVING

Mean children ever born (CEB) and children surviving (CS) by selected background characteristics of currently married women aged 15-44 years, Andaman & Nicobar Islands, 2002-04

Background characteristic	Mean children ever born			Mean children surviving			Number of women
	Total	Male	Female	Total	Male	Female	
Age group (years)							
<25	1.0	0.6	0.5	1.0	0.5	0.4	348
25-29	1.8	0.9	0.8	1.7	0.9	0.8	531
30-34	2.4	1.2	1.2	2.3	1.2	1.2	383
35-39	2.6	1.3	1.3	2.5	1.3	1.2	299
40-44	2.8	1.6	1.2	2.8	1.6	1.2	220
Marital duration							
0-4	0.8	0.5	0.3	0.8	0.5	0.3	403
5-9	1.9	0.9	1.0	1.9	0.9	1.0	441
10-14	2.3	1.2	1.1	2.3	1.2	1.1	409
15+	2.8	1.5	1.3	2.7	1.5	1.3	529
Residence							
Rural	2.0	1.1	1.0	2.0	1.1	0.9	1,467
Urban	1.9	1.0	0.9	1.9	0.9	0.9	315
Religion							
Hindu	2.1	1.1	1.0	2.0	1.1	0.9	915
Muslim	2.0	1.0	1.0	1.9	1.0	1.0	138
Christian	2.0	1.0	1.0	2.0	1.0	0.9	704
Other	(2.0)	(1.1)	(0.8)	(2.0)	(1.1)	(0.8)	26
Caste/tribe #							
Scheduled caste	2.0	1.1	1.0	2.0	1.0	0.9	187
Scheduled tribe	2.0	1.0	1.0	2.0	1.0	0.9	517
Other backward class	(2.1)	(1.1)	(1.0)	(2.0)	(1.1)	(0.9)	38
Other	2.0	1.1	1.0	2.0	1.0	0.9	925
Education							
Non-literate	2.5	1.3	1.3	2.5	1.2	1.2	392
0-9@ years	2.0	1.1	0.9	2.0	1.1	0.9	866
10 years & above	1.6	0.8	0.8	1.6	0.8	0.8	524
Standard of living index							
Low	2.1	1.1	1.0	2.1	1.1	1.0	429
Medium	2.1	1.1	1.0	2.1	1.1	1.0	629
High	1.9	1.0	0.9	1.9	1.0	0.9	724
All women	2.0	1.1	1.0	2.0	1.0	0.9	1,782

Note: # Total number may not add up to N due to don't know and missing cases. @ Literate women with no year of schooling are included. () based on less than 50 unweighted cases.

Women with longer marital duration have higher mean children ever born. On the average, women who are married for 15 or more years have 2.8 children ever born and 2.7 of them are surviving. There is not much rural-urban divide in terms of mean children ever born with 2.0 children in rural areas and 1.9 children in urban areas. The mean children ever born to women who are Hindu, Muslim and Christian religions are 2.1, 2.0 and 2.0 respectively. The corresponding mean surviving children are 2.0, 1.9 and 2.0 for these religious groups. The average children ever born also does not vary much by caste/tribe of the eligible women. For women belonging to scheduled caste and scheduled tribe, the mean children ever born is 2.0 each, for other backward classes is 2.1 and other castes is 2.0. For all caste groups, the mean number of surviving children is 2, shared almost by one surviving male and one surviving female children on the average.

The mean children ever born is higher for non-literate women (2.5) than women who have completed 0-9 years of schooling (2.0) and 10 or more years of schooling (1.6). All the children ever born for women corresponding to these educational levels are reported to be survived to the survey date. Further the mean children ever born for women classified into low, medium and high standard of living groups by SLI are 2.1, 2.1 and 1.9 respectively. For the union territory of Andaman & Nicobar Islands, the DLHS-RCH shows inverse association between mean children ever born and educational attainment of women, while it is not so for the level of household economic comfort.

3.6 Completed Fertility by Districts

The levels of completed fertility, as measured by mean children ever born to women of 40-44 years, by districts in Andaman & Nicobar Islands together with mean number of surviving children are shown in Table 3.6. On the average, women on the verge of completing reproductive period have given birth to 2.8 children in their reproductive life, almost all of which are surviving. Completed fertility in Andaman & Nicobar Islands differs less in the two districts. Completed fertility in terms of mean children ever born is slightly higher in Andamans (2.9) than in Nicobars (2.7). Mean children ever born in both the districts of Andaman & Nicobar Islands is slightly less than 3 children. It is also true that in the two districts mean number of male children is slightly more than the mean number of female children born alive to women in the 40-44 year age group. Nicobars recorded a difference of 0.1 children between the mean children ever born and mean number of surviving children. Looking at the absolute difference between mean children ever born and mean number of surviving children, it seems that infant and child mortality is quite low and differs less in the two districts of Andaman & Nicobar Islands.

Table 3.6 COMPLETED FERTILITY BY DISTRICT						
Mean children ever born (CEB) and children surviving (CS) to currently married women aged 40-44 by district, Andaman & Nicobar Islands, 2002-04						
District	Mean children ever born			Mean children surviving		
	Total	Male	Female	Total	Male	Female
Andamans	2.9	1.7	1.2	2.9	1.7	1.2
Nicobars	2.7	1.4	1.3	2.6	1.4	1.2
Andaman & Nicobar Islands	2.8	1.6	1.2	2.8	1.6	1.2

3.7 Birth Order

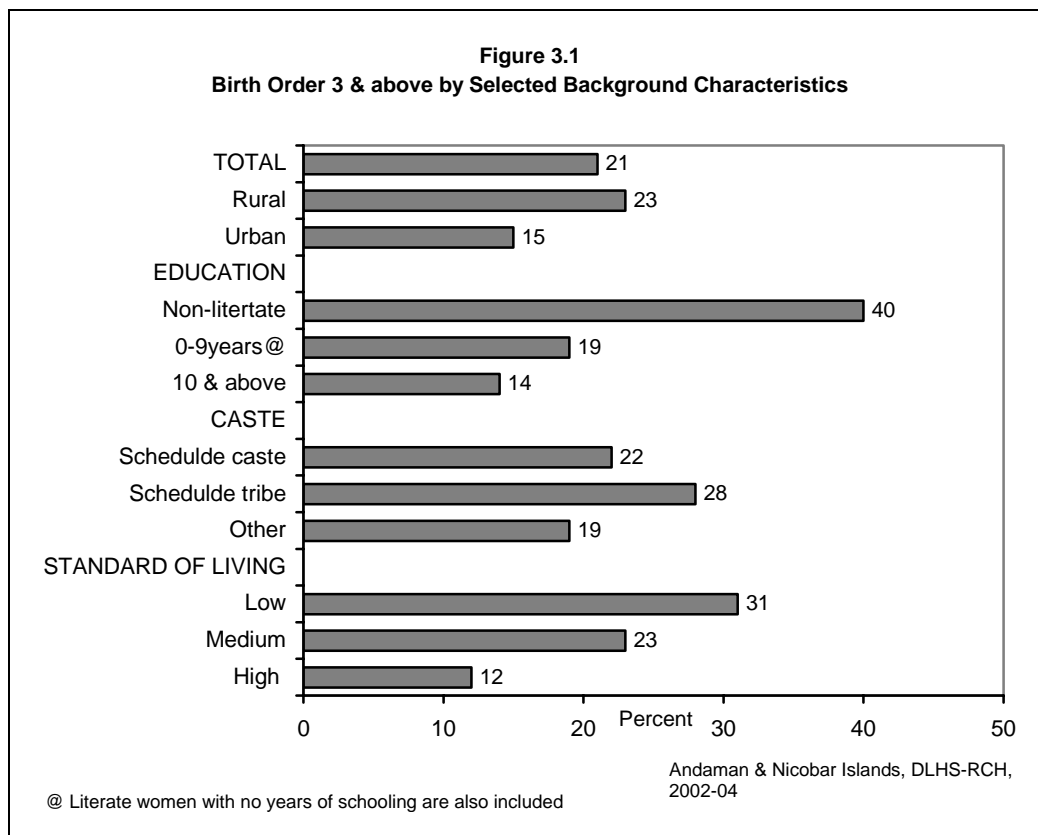
Birth order distribution by selected background characteristics of women is provided in Table 3.7 and Figure 3.1. This distribution can be used as a measure of fertility in the absence of formal measures of fertility, such as, crude birth rate and total fertility rate.

Table 3.7 BIRTH ORDER						
Percent distribution of births during three years preceding the survey by birth order by selected background characteristics, Andaman & Nicobar Islands, 2002-04						
Background characteristic	Birth order				Total percent	Number of births
	1	2	3	4+		
Age of women						
20-24	65.7	30.3	3.7	0.3	100.0	219
25-29	37.4	40.1	15.0	7.5	100.0	265
30-34	21.8	35.6	27.6	15.0	100.0	89
35-39	(9.1)	(24.2)	(39.4)	(27.3)	(100.0)	36
Place of residence						
Rural	44.4	33.1	15.5	7.0	100.0	497
Urban	45.9	39.3	9.3	5.4	100.0	127
Education (Years of schooling)						
Non-literate	26.7	33.6	25.4	14.3	100.0	111
0-9@ years	47.5	33.5	12.5	6.5	100.0	318
10 years & above	50.3	36.1	10.8	2.8	100.0	195
Religion						
Hindu	46.4	37.8	10.8	5.0	100.0	319
Muslim	(43.8)	(35.4)	(16.7)	(4.2)	(100.0)	45
Christian	43.9	29.0	17.4	9.7	100.0	253
Caste/tribe #						
Scheduled caste	42.9	34.8	18.2	4.1	100.0	62
Scheduled tribe	40.9	31.5	16.8	10.8	100.0	195
Other	45.3	36.1	13.0	5.5	100.0	306
Standard of living index						
Low	36.0	32.7	17.9	13.5	100.0	165
Medium	43.2	33.8	16.5	6.5	100.0	221
High	52.1	36.0	9.7	2.2	100.0	238
Total	44.7	34.3	14.3	6.7	100.0	624

Note: Total includes 14 and 1 case in age of women 15-19 and 40-44 respectively, 7 cases in religion-other, 16 cases in caste/tribe-other backward class were not shown separately. # Total number of births may not add upto N due to don't know and missing cases. () Based on less than 50 unweighed cases.

For the union territory of Andaman & Nicobar Islands, about 45 percent of the births in the three-year period preceding the survey were of first order, 34 percent were of second order and the remaining 21 percent were of order 3rd and higher order births. By current age of eligible women, more than two-fifths of births to women in the age group 30-34 years and 35-39 years are 3rd and higher order births. For women of 15-19 years, 66 percent births are of first order and 30 percent births are of second order. Birth order distribution is slightly more biased towards higher order births more in the case of eligible women in rural areas than in urban areas. Of the total births of non-literate women, 40 percent are 3rd and higher order births, followed by 19 percent for women with 0-9 years of schooling and 14 percent for women who had 10 or more years of schooling. In short, births occurred to non-literate women are of higher order whereas lower order births were occurred to more women who are literate. Looking at the religious differentials in birth order distribution, it is observed that 27 percent of births occurred to Christian women are 3rd and higher order births. For Hindu and Muslim women, the 3rd and higher order births constitute one-sixth and one-fifth respectively. The occurrence of births of

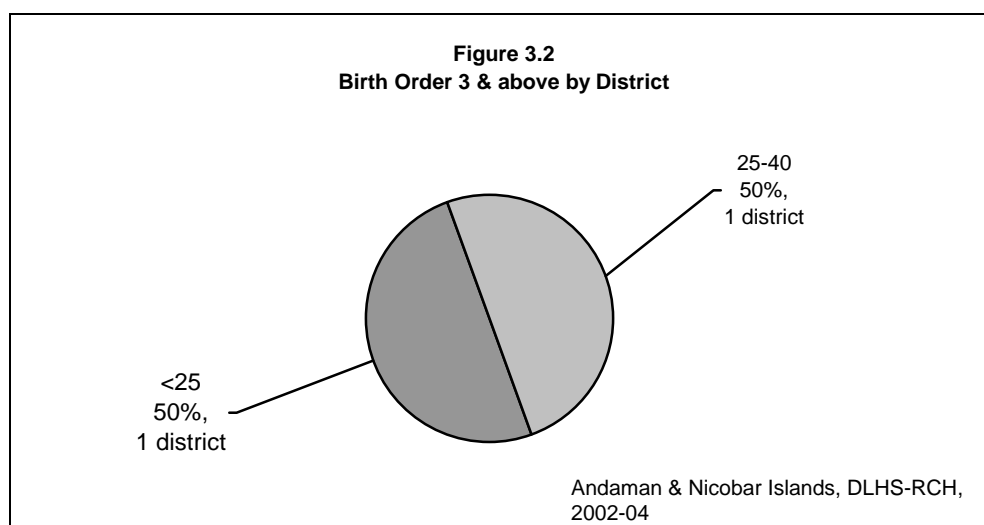
order 3 and above is more among scheduled tribe women (28 percent) than among scheduled caste (22 percent) and other castes (19 percent) women. Incidence of births of order 3 and above for women classified by household standard of living index is 12 percent for high, 23 percent for medium and 31 percent for low living standard household women.



3.8 Birth Order by Districts

Table 3.8 and Figure 3.2 show the birth order distribution by districts in Andaman & Nicobar Islands. The proportion of births of order 3rd and above is lower in Andamans district (16 percent) as compared to Nicobars district (27 percent).

Table 3.8 BIRTH ORDER BY DISTRICT				
Percent distribution of births during three years preceding the survey by birth order, according to district, Andaman & Nicobar Islands, 2002-04				
District	Birth order			
	1	2	3	4+
Andamans	49.0	35.5	10.2	5.3
Nicobars	40.4	33.0	18.5	8.1
Andaman & Nicobar Islands	44.7	34.3	14.3	6.7



3.9 Fertility Preferences

The distribution of currently married women desiring additional children and preferred sex of additional children by number of living children of the women is shown vividly in Table 3.9 and Figure 3.3. Out of the 161 women with no living child, 24 percent are currently pregnant and 5 percent are using spacing methods, while 51 percent want to have children within two years, 7 percent are undecided about the timing of birth and one percent desired not to have any children. Among the currently married women, the desire for additional children dwindles down with increasing number of living children. As many as 22 percent of the women having one living child want additional children within two years, 3 percent after two years, 13 percent are undecided about the timing of the next child, 10 percent of them want no more additional children, while 7 percent are sterilized, and 24 percent are using spacing methods. Use of permanent means of contraception tends to be accelerated with number of living children. In the union territory of Andaman & Nicobar Islands, out of the 1,782 surveyed representative women, 11 percent desired to have additional children within two years, 15 percent want no more children, 6 percent are currently pregnant and 46 percent are using terminal contraceptive methods. A total of 367 women want additional children irrespective of the number of living children. Out of 112 women who have no living children and desire for additional children, about 9 percent want a boy as the first child and 2 percent desired a girl, while for 55 percent, the sex of the child is immaterial and 34 percent leave it to God. With increasing number of living children, desire for male child increases, in general, though a sizeable proportion of women expressed desire for female child and a significant proportion of women desiring additional children expressed that the sex of the child was immaterial.

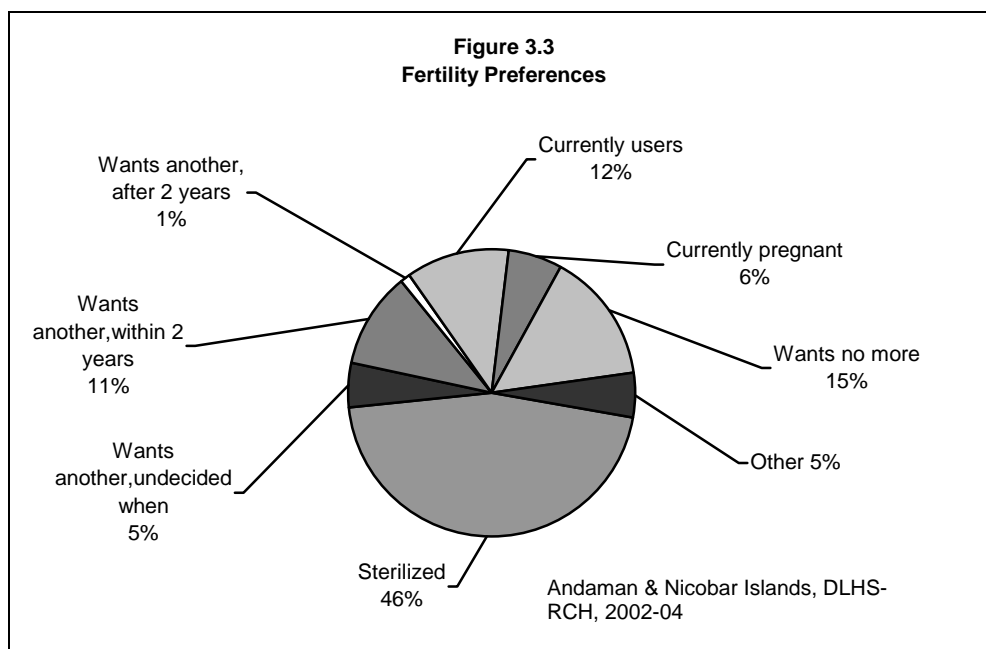


Table 3.9 FERTILITY PREFERENCE
Percent distribution of currently married women by desire for children, according to number of living children, Andaman & Nicobar Islands, 2002-04

Desire for children	Number of living children					Total
	0	1	2	3	4+	
Desire for additional child						
Wants another soon ¹	50.8	21.7	2.3	0.3	0.0	10.6
Wants another later ²	0.8	3.1	0.5	0.0	0.0	1.0
Want another, undecided when	7.1	12.5	2.3	0.0	1.9	4.6
Undecided	5.9	8.9	0.8	1.3	1.9	3.4
Up to God	4.8	0.2	0.8	0.9	0.0	1.0
Want no more	1.2	9.7	17.5	18.9	21.9	14.9
Sterilized	0.0	7.3	62.5	69.4	67.5	45.8
Currently users ³	5.1	23.8	11.7	8.1	2.3	12.2
Currently pregnant	24.3	11.6	1.3	1.0	3.9	6.0
Declared infecund	0.0	1.0	0.4	0.2	0.8	0.5
Missing	0.0	0.3	0.0	0.0	0.0	0.1
Total percent	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	161	417	665	362	177	1,782
Preferred sex of additional children						
Boy	9.4	12.8	(27.8)	*	*	13.2
Girl	1.5	15.5	(13.9)	*	*	11.3
Doesn't matter	55.3	57.2	(33.3)	*	*	52.4
Upto God	33.8	14.5	(25.0)	*	*	23.0
Total percent	100.0	100.0	(100.0)	*	*	100.0
Number of women	112	195	44	9	7	367

Note: ¹ Wants next births within 2 years. ² Wants to delay next birth for 2 or more years. ³ Other than sterilization. () based on less than 50 unweighted cases. * Percentage not shown – based on very few cases.

3.10 Pregnancy Outcomes

Table 3.10 shows distribution of pregnancy outcomes including live birth, stillbirth, induced abortion and spontaneous abortion by districts in Andaman & Nicobar Islands. For the union territory as a whole, 97 percent of pregnancies ended in live births and around one percent each in stillbirths, induced abortions and spontaneous abortions. Slight rural-urban divide in the outcomes of pregnancies is found in the union territory. In Andaman & Nicobar Islands, the proportion of pregnancies ending in live births is 95 percent in Andamans and 98 percent in Nicobars. The incidence of stillbirths is less than one percent in both the districts. Induced abortions are reported only in Andamans district (2 percent). Spontaneous abortions are reported more in Andamans district (2 percent) than in Nicobars district (0.8 percent).

Table 3.10 OUTCOMES OF PREGNANCY					
Percent distribution of all pregnancies of currently married women aged 15-44 years by their outcomes during three years preceding the survey, according to districts, Andaman & Nicobar Islands, 2002-04					
Districts	Live birth	Stillbirth	Induced abortion	Spontaneous abortion	Total percent
UT-Rural	97.6	0.5	0.7	1.2	100.0
UT-Urban	93.3	1.4	3.0	2.3	100.0
UT-Total	96.8	0.7	1.1	1.4	100.0
Andamans	95.3	0.5	2.2	2.1	100.0
Nicobars	98.4	0.7	0.0	0.8	100.0

CHAPTER IV

MATERNAL HEALTH CARE

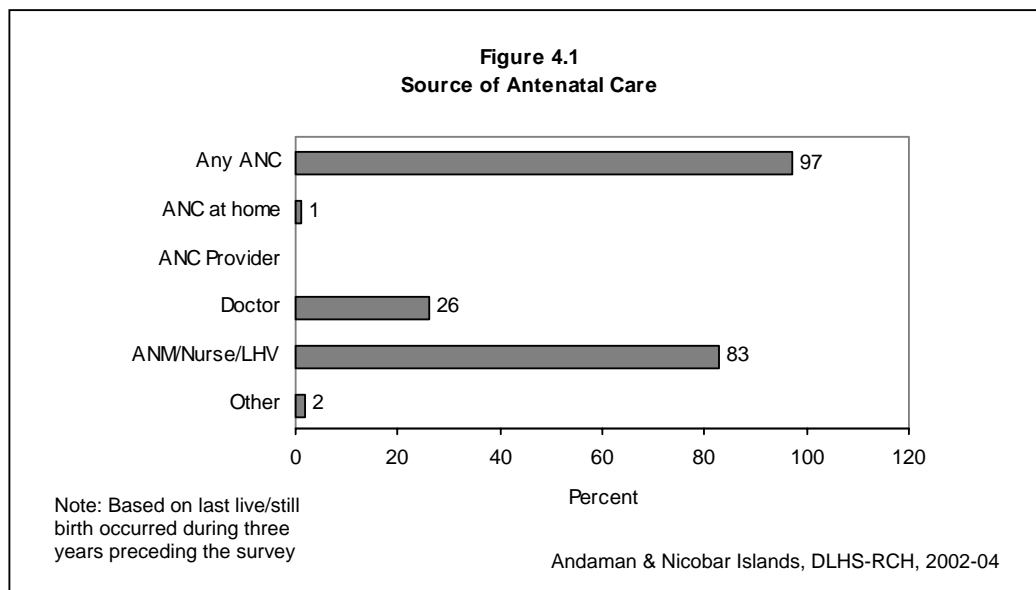
Provisions of maternal health care services to ensure safe motherhood is one of the major components of the Reproductive and Child Health (RCH) programme. The RCH programme services for antenatal care, includes at least three antenatal care visits, iron prophylaxis for pregnant and lactating women, at least one dose of tetanus toxoid vaccine, detection and treatment of anaemia in mothers, and management and referral of high-risk pregnancies, natal care, that is encouragement of safe delivery, post-natal care, and management of unwanted pregnancies. In rural areas, the government delivers reproductive health and other health services through its network of Sub-Centres (SCs), Primary Health Centres (PHCs) and other health facilities. In addition, pregnant women and children can get services from private maternity homes, hospitals, private practitioners, and in some cases non-governmental organisations (NGOs) and trust hospitals. In urban areas, reproductive health services are available mainly through government or municipal hospitals, Urban Health Posts (UHPs), Urban Family Welfare Centres (UFWCs), hospitals and nursing homes operated by NGOs, and private nursing and maternity homes.

The National Population Policy (NPP), 2000 adopted by the Government of India (Ministry of Health and Family Welfare, 2000) reiterates the Government's commitment to the safe motherhood programme within the wider context of reproductive health. Among the national socio-demographic goals for 2010 specified by the policy, several goals pertain to safe motherhood, that 80 percent of all deliveries should take place in institutions by 2010, hundred percent deliveries should be attended by trained personnel, and the maternal mortality ratio should be reduced to a level below 100 per 100,000 live births. Empowering women for improved health and nutrition is one of the 12 strategic themes identified in the policy to be pursued either as stand-alone programmes or as intersectoral programmes.

In DLHS-RCH Phase-I, to all the eligible women who had their last pregnancy after January 1, 1999 a separate section on the status of maternal health and utilisation of maternal health care services was canvassed. In Phase-II, the same section was canvassed to all the eligible women who had their last pregnancy after January 1, 2001. The women whose last pregnancy terminated into live/still birth were asked about the details of antenatal, natal and post-natal care they received; pregnancy, delivery and post-delivery complications they suffered from and the treatment seeking behaviour in case of complications. Women whose last pregnancy terminated into abortion, either spontaneous or induced, were asked about the utilisation of safe abortion services and the post-abortion complications they experienced. This chapter presents information on antenatal, natal and postnatal care received by women whose last pregnancy had terminated during the three years preceding the survey as live birth or as stillbirth.

4.1 Antenatal Check-Ups

Women who had given birth during the three years preceding the survey were asked whether they had gone for antenatal check-ups outside the home, and if they had, what type of service provider had given them the check-ups. They were also asked whether any health worker had visited them at home to provide antenatal check-ups. Table 4.1 and Figure 4.1 present the percentage of women who had given birth during the three years preceding the survey, and received antenatal check-ups by source of antenatal check-ups according to some selected background characteristics. Results show that 97 percent of the women received antenatal check-ups during the three years preceding the survey, almost same as that of RCH Round I (96 percent). Around 26 percent of women received antenatal check-ups from doctors, and 83 percent from ANM/Nurse/LHV. Less than one percent women received antenatal check-ups only at the doorsteps from the ANMs or health worker.



Antenatal check-ups are received by more than 95 percent of the women irrespective of their background characteristics. The percentage of women who received antenatal check-ups from doctors is relatively higher in urban areas (39 percent) than in rural areas (23 percent), while more or less the same proportion of urban (82 percent) and rural (84 percent) women received antenatal check-ups from auxiliary nurse midwife, nurse or LHVs.

The proportion of women who received antenatal check-ups from a doctor is relatively more among more educated women, while it increased steadily with the level of the standard of living index. About 24 percent non-literate women as compared to 37 percent having education of more than 10 years received ANC from doctors. Similarly, 18 percent women belonging to households with a low standard of living against 34 percent of that from a high standard of living fall in this category. The proportion of Hindu and Muslim women who received antenatal check-ups from doctors (30-33 percent) was relatively higher than that of Christian women (16 percent). Around 17 percent of scheduled caste women and 19 percent of scheduled tribe women received antenatal

check-ups from doctors, while it was 27 percent for other caste or tribe women. Women from scheduled tribes were relatively more likely to receive antenatal check-ups only at home from auxiliary nurse midwives. Around 2 percent of scheduled tribe women received antenatal check-ups only at home from ANMs, while it was less than one percent among scheduled castes and other caste or tribe women.

Table 4.1 ANTENATAL CHECK-UP							
Percentage of women* who received any antenatal check-up (ANC) during pregnancy by source of antenatal provider, according to selected background characteristics, Andaman & Nicobar Islands, 2002-04							
Background characteristic	Any ¹ antenatal check-up	Antenatal check-up only at home by ANM	Health personnel providing ANC ²				Number of women
			Doctor	ANM/ Nurse/ LHV	Other health professional	Other ³	
Age group							
Less than 30 years	96.4	1.0	26.0	83.2	1.4	0.8	521
30 years & above	98.8	0.6	26.4	84.0	2.0	0.0	181
Children ever born							
1	97.2	0.0	27.4	83.8	1.0	0.4	274
2	96.0	0.3	31.0	83.7	1.2	1.3	254
3+	98.1	3.2	17.5	81.8	3.1	0.0	171
Residence							
Rural	97.4	1.1	23.1	83.6	1.9	0.8	572
Urban	95.3	0.0	39.1	82.2	0.0	0.0	131
Education							
Non-literate	96.3	0.0	24.1	77.1	8.0	2.6	124
0-9 @ years	96.8	1.7	20.2	85.8	0.0	0.0	362
10 years & above	97.8	0.0	37.2	82.9	0.5	0.5	216
Religion							
Hindu	97.1	0.4	33.0	83.9	0.8	0.8	354
Muslim	97.4	0.0	29.9	87.8	0.0	0.0	54
Christian	96.8	1.7	16.4	82.8	2.9	0.5	288
Caste/tribe#							
Scheduled caste	98.7	0.0	16.9	91.0	0.0	0.0	84
Scheduled tribe	95.6	2.3	18.5	77.1	3.9	0.7	209
Other	97.6	0.4	26.6	86.0	0.8	0.8	337
Standard of living index							
Low	96.0	2.3	17.5	83.3	3.1	0.8	190
Medium	96.4	0.7	24.6	83.0	0.7	0.7	251
High	98.4	0.0	33.8	83.7	1.3	0.4	262
Availability of health facility⁴ in the village							
No	97.3	0.5	28.6	84.8	0.0	1.2	125
Yes	97.4	1.2	21.6	83.3	2.5	0.6	447
Total	97.0	0.9	26.1	83.4	1.6	0.6	703

Note: * Women who had their last live/still birth since 1-1-1999/1-1-2001. Total includes 4 women with zero parity, 7 cases with other in religion and 21 cases with other backward class respectively in caste/tribe were not shown separately. ¹ Antenatal check-ups either at home or outside from home at health facility. ² Antenatal check-ups outside home and percentage add more than 100.0 due to multiple responses. ³ Other also includes trained and untrained *dai*. # Total figure may not add to N due to do not know and missing cases. @ Literate women with no years of schooling are also included. ⁴ Includes sub-centre, primary health centre, community health centre or referral hospital, government hospital, and government dispensary within the village.

4.2 Antenatal Check-Ups at Health Facility

DLHS-RCH asked women who had a birth during the three years preceding the survey whether the women had received antenatal check-ups, and if they had, from where they had availed such services.

Table 4.2 PLACE OF ANTENATAL CHECK-UP									
Percentage of women* who received any antenatal check-ups (ANC) during pregnancy by source and place of antenatal check-ups, according to selected background characteristics, Andaman & Nicobar Islands, 2002-04									
Background characteristic	Antenatal check-up only at home	Place of antenatal check-ups ¹							Number of women
		Government health facility ²	Private health facility ³	ISM ⁴ facility					
				PHC	SC	Govt.	Private	Other	
Age group									
Less than 30 years	1.0	93.6	1.1	34.1	32.2	0.0	1.2	0.2	521
30 years & above	0.6	95.9	1.2	34.4	41.0	0.0	0.6	0.6	181
Children ever born									
1	0.0	94.2	1.3	32.1	37.6	0.0	2.1	0.3	274
2	0.3	94.5	1.2	33.8	29.0	0.0	0.6	0.0	254
3+	3.2	93.7	0.7	39.3	37.4	0.0	0.0	0.6	171
Residence									
Rural	1.1	95.3	0.2	40.4	38.7	0.0	1.0	0.1	572
Urban	0.0	89.4	5.1	6.9	15.8	0.0	1.5	0.8	131
Education									
Non-literate	0.0	95.6	0.7	29.7	42.7	0.0	0.0	0.0	124
0-9 @ years	1.7	94.4	0.4	36.1	38.9	0.0	0.5	0.0	362
10 years & above	0.0	93.1	2.5	33.7	22.6	0.0	2.5	0.9	216
Religion									
Hindu	0.4	93.6	2.0	38.8	25.1	0.0	1.6	0.5	354
Muslim	0.0	95.7	0.0	18.2	26.0	0.0	1.7	0.0	54
Christian	1.7	94.8	0.0	31.4	48.7	0.0	0.3	0.0	288
Caste/tribe#									
Scheduled caste	0.0	98.2	0.0	38.2	44.9	0.0	0.5	0.0	84
Scheduled tribe	2.3	93.1	0.1	25.5	52.7	0.0	0.2	0.0	209
Other	0.4	94.6	2.0	36.5	24.0	0.0	1.0	0.6	337
Standard of living index									
Low	2.3	93.2	0.5	51.1	43.6	0.0	0.0	0.0	190
Medium	0.7	94.0	0.1	29.6	37.6	0.0	1.7	0.0	251
High	0.0	95.1	2.6	26.9	25.3	0.0	1.2	0.7	262
Availability of health facility⁵ in the village									
No	0.5	96.8	0.0	37.7	46.8	0.0	0.0	0.0	125
Yes	1.2	94.9	0.3	41.2	36.4	0.0	1.2	0.2	447
Total	0.9	94.2	1.1	34.2	34.5	0.0	1.1	0.3	703

Note: * Women who had their last live/still birth since 1-1-1999/1-1-2001. Total includes 4 women with zero parity, 7 cases with other in religion and 21 cases with other backward class respectively in caste/tribe were not shown separately. # Total figure may not add to N due to do not know and missing cases. @ Literate women with no years of schooling are also included. ¹ Antenatal check-ups outside home and percentage add more than 100.0 due to multiple responses. ² Includes sub-centre, primary health centre, community health centre or rural hospital, urban health centre/ urban health post/ urban family welfare centre, government hospital or dispensary. ³ Includes Private hospital/clinic or non-governmental hospital/ trust hospital or clinic. ⁴ Indian system of medicine. ⁵ Includes sub-centre, primary health centre, community health centre or referral hospital, government hospital, and government dispensary within the village.

Table 4.2 shows the percentage of women who had received antenatal check-ups during pregnancy by place. During pregnancy, women received antenatal check-ups from multiple sources such as, health workers providing ANC at home, Government health facility, private health facility, and at Indian System of Medicine etc. Women who received antenatal check-ups both at home and outside the home are categorised as having received care outside the home. As high as 94 percent of women received antenatal check-ups at Government health facility, including 34 percent through primary health centre and 35 percent through sub-centre, while only one percent each received ANC at a private health facility or at private Indian system of medicine. As mentioned above women availed antenatal check-ups from multiple sources. Women who were visited by an ANM might have also visited government and/ or private health facilities including Indian system of medicine.

A relatively higher proportion of women from rural areas availed government health facilities for antenatal check-ups than those from urban areas, but, a comparatively higher proportion of women from urban areas (5.1 percent) availed private health facilities for antenatal check-ups than women from rural areas (0.2 percent). More or less similar proportion of women with different background characteristics received antenatal check-ups at Government health facilities.

4.3 Antenatal Check-Ups by Districts

Table 4.3 indicates the antenatal coverage in Andaman & Nicobar Islands that is almost the same in both the districts as 98 percent of women from Andamans and 97 percent from Nicobars got some kind of antenatal check-ups for their last births during the three years preceding the survey. Antenatal check-ups received from doctor was slightly lower in Nicobars (24 percent) than in Andamans (28 percent). Also, a relatively lower proportion of women from Nicobars (79 percent) received antenatal check-ups by ANM/Nurse/LHV than those from Andamans (86 percent).

Table 4.3 ANTENATAL CHECK-UPS BY DISTRICT							
Percentage of women* who received any antenatal care (ANC), by source and place of antenatal check-ups by district, Andaman & Nicobar Islands, 2002-04							
District	Any ¹ antenatal check-up	Antenatal check-up only at home by ANM	Health personnel providing ANC		Place of antenatal check-ups		
			Doctor	ANM/ Nurse	Government ² health facility	Private ³ health facility	ISM ⁴ facility
Andamans	97.6	0.7	28.1	87.5	94.2	2.2	0.8
Nicobars	96.5	1.0	24.4	79.2	94.4	0.1	1.3
Andaman & Nicobar Islands	97.0	0.9	26.1	83.4	94.2	1.1	1.0

Note: * Women who had last live/still birth during three years preceding the survey. ¹ Antenatal check-ups either at home or health facility. ² Includes sub-centre, primary health centre, community health centre or rural hospital, urban health centre/ urban health post/ urban family welfare centre, government hospital or dispensary. ³ Includes Private hospital/clinic or non-governmental hospital/ trust hospital or clinic. ⁴ Either government or private Indian system of medicine.

The extent of utilisation of government health facilities for antenatal check-ups was much higher than that of private health facilities. The antenatal check-ups coverage through government facilities was almost the same in Andamans and Nicobars districts, however, around 2 percent of the women in Andamans visited private health facility, while a very few women did so in Nicobars. In Andaman & Nicobar Islands, only around one percent of pregnant women in Andamans and Nicobars districts availed the Indian system of Medicine (either government or private) for an antenatal check-ups.

4.4 Components of Antenatal Check-ups

Women who received any kind of antenatal check-ups were asked whether they received each of the several components of antenatal check-ups at least once during their pregnancy. Table 4.4 presents the percentage of women who received specific components of check-ups by residence. Except for X-rays (which are not recommended as a standard component of antenatal care), all of the measurements and tests are part of essential obstetric care or are required for monitoring high-risk pregnancies.

Table 4.4 COMPONENTS OF ANTENATAL CHECK-UPS			
Percentage of women* who received an antenatal check-up by specific components of antenatal check-up, according to residence, Andaman & Nicobar Islands, 2002-04			
Components of antenatal check-ups	Total	Rural	Urban
Antenatal measurements/tests			
Weight measured	98.5	98.3	99.3
Height measured	96.7	96.9	96.0
Blood pressure checked	98.6	98.5	99.3
Blood tested	96.7	96.1	99.3
Urine tested	98.0	97.7	99.3
Abdomen examined	93.7	92.8	97.7
Internal examined	47.2	47.9	43.9
Breast examined	55.0	53.5	61.7
X-ray	9.5	9.8	8.0
Sonography /ultrasound	27.4	22.5	49.1
Amniocentesis	5.8	6.5	2.5
Antenatal advice			
Diet	89.6	89.0	92.0
Danger signs of pregnancy	47.9	48.9	43.5
Delivery care	53.9	54.3	52.3
Breast feeding	59.6	60.2	57.0
New born care	47.0	45.7	53.0
Family planning	58.9	58.9	58.8
Number of women who received any antenatal check-up	682	557	125
Note: * Women who had their last live/still birth since 1-1-1999/1-1-2001.			

Around 99 percent each of women were weighed and had their blood pressure checked, and 98 percent had an abdominal examination as part of the antenatal check-ups. Other common components of antenatal check-ups were blood test (97 percent), urine test (98 percent), the measurement of height (97 percent), internal examination (47 percent), and breast examination (55 percent). About 27 percent of women had a sonogram or ultrasound, 10 percent had an X-ray and 6 percent of women reported that they had amniocentesis test. All of these measurements or producers were performed more often during antenatal check-ups in urban areas than in rural areas.

The types of advices received by women who had antenatal check-ups for last live/still births during three years preceding the survey are also presented in Table 4.4. Advice on diet was given to 92 percent of urban women, 89 percent of rural women and 90 percent in general. About 48 percent of the women received advice on danger signs of pregnancy, while 54 percent received advice on delivery care. A significant proportion of women also received advice on family planning (59 percent), on breastfeeding (60 percent), and on newborn care (47 percent).

4.5 Antenatal Care Services

In India, the Reproductive and Child Health Programme includes all pregnant women, whom should be registered in the first 12-16 weeks (Ministry of Health and Family Welfare, 1997). Accordingly, the first antenatal check-ups should take place at latest during the first trimester of the pregnancy. It also includes the provision of at least three antenatal care visits, of at least one tetanus toxoid injection, and supplementary iron in the form of IFA tablets daily for 100 days. To assess whether the women had received all the care during pregnancy, information was collected regarding number of antenatal visits, timing of the first visit, receipt of tetanus toxoid injection and supplementation of iron folic acid tablets. The results are presented in Table 4.5. In Andaman & Nicobar Islands, 91 percent had four or more antenatal check-ups. At least four antenatal check-ups were received by 92 percent of women in urban areas compared with 91 percent of women in rural areas. Number of visits for antenatal care varies little by education, children ever born, religion, caste and standard of living index. Around 86 percent of non-literate, 92 percent of literate women (educated below high school) and 94 percent of women who had 10 or more years of schooling visited for a minimum of four antenatal care services. About 90 percent of women with parity one received four or more antenatal check-ups compared to 94 percent of the women with parity 3 and above.

Table 4.5 ANTENATAL CARE

Percent distribution of women who had live/still births during three years preceding the survey by number of antenatal check-ups, the stage of pregnancy at the time of first check-up, the number of tetanus toxoid injections received and were given iron folic acid (IFA) tablets/syrup during pregnancy, and percentage who received full antenatal check-ups by some selected background characteristics, Andaman & Nicobar Islands, 2002-04

Antenatal care indicators	Total	Residence		Education			Children ever born		
		Rural	Urban	Non-literate	0-9@ years	10 years & above	1	2	3+
Number of ANC visits									
No visit	3.0	2.6	4.7	3.7	3.2	2.2	2.8	4.0	1.9
1-3	5.7	6.3	3.2	10.2	5.2	3.9	7.7	4.3	4.1
4+	91.3	91.1	92.1	86.1	91.6	93.8	89.5	91.7	94.1
Stage of pregnancy at the time of the first antenatal check-up									
No antenatal check-up	3.0	2.6	4.7	3.7	3.2	2.2	2.8	4.0	1.9
First trimester	46.5	44.8	53.8	51.0	42.7	50.1	50.1	41.0	48.3
Second trimester	49.5	51.4	41.6	42.8	53.6	46.6	45.5	54.7	48.8
Third trimester	1.0	1.2	0.0	2.5	0.4	1.1	1.7	0.3	1.0
Women who received TT									
No TT	1.6	1.3	2.8	1.8	1.8	1.1	0.8	1.6	2.0
1	9.2	10.0	5.8	13.1	6.5	11.5	3.9	11.8	14.2
2+	86.8	86.4	88.9	83.7	88.3	86.2	94.2	83.6	80.1
Do not remember/missing	2.4	2.4	2.5	1.4	3.4	1.2	1.1	2.9	3.7
Women who received IFA tablets/syrup									
No IFA/syrup	2.0	1.9	2.1	1.8	1.5	3.0	2.5	1.2	1.8
Received but not consumed	2.4	2.3	2.8	0.3	2.8	3.0	2.0	2.8	2.6
Consumed one IFA per day	78.6	76.5	87.7	81.0	76.2	81.2	76.3	80.2	80.0
Received 100+ IFA tablets/syrup	84.1	82.3	91.7	74.6	85.9	86.5	86.2	85.5	78.7
Percentage of women who received full ¹ antenatal check-ups	77.8	76.1	85.2	69.9	78.9	80.6	80.3	77.6	74.3
Number of women	703	572	131	124	362	216	274	254	171

Note: Total includes 4 women with zero parity who were not shown separately. @ Literate women with no years of schooling are also included. ¹ At least three visits for antenatal check-ups, at least one TT injection received and were given adequate amount of IFA tablets/syrup.

Continued...

Table 4.5 ANTENATAL CARE (contd)

Percent distribution of women who had live/still births during three years preceding the survey by number of antenatal check-ups, the stage of pregnancy at the time of first check-up, the number of tetanus toxoid injections received and iron and were given iron folic acid (IFA) tablets/syrup during pregnancy, and percentage who received full antenatal check-ups by some selected background characteristics, Andaman & Nicobar Islands, 2002-04

Antenatal care indicators	Religion			Caste#			Standard of living index			Availability of health facility ² in the village	
	Hindu	Muslim	Christian	Scheduled caste	Scheduled tribe	Other	Low	Medium	High	No	Yes
Number of ANC visits											
No visit	2.9	2.6	3.2	1.3	4.4	2.4	4.0	3.6	1.6	2.7	2.6
1-3	3.8	4.9	8.4	2.9	10.8	4.2	8.9	4.2	4.8	6.5	6.2
4+	93.3	92.5	88.4	95.8	84.8	93.5	87.1	92.2	93.6	90.8	91.2
Stage of pregnancy at the time of the first antenatal check-up											
No antenatal check-up	2.9	2.6	3.2	1.3	4.4	2.4	4.0	3.6	1.6	2.7	2.6
First trimester	48.2	55.5	41.9	51.3	38.1	49.1	37.1	49.2	50.7	42.1	45.6
Second trimester	48.0	39.9	53.9	47.4	56.1	47.6	56.8	46.8	46.9	53.1	50.9
Third trimester	0.9	2.0	1.0	0.0	1.4	1.0	2.1	0.4	0.8	2.1	1.0
Women who received TT											
No TT	1.5	5.2	0.9	0.0	1.3	1.6	2.9	0.7	1.3	0.8	1.4
1	6.9	8.4	12.4	10.6	12.1	8.4	10.4	9.7	8.0	12.5	9.3
2+	87.9	83.4	85.9	87.6	86.6	86.6	83.4	87.0	89.2	84.3	86.9
Do not remember/missing	3.7	3.0	0.7	1.8	0.0	3.4	3.3	2.6	1.5	2.4	2.3
Women who received IFA tablets/syrup											
No IFA/syrup	1.2	6.8	2.1	0.0	3.2	0.9	2.1	1.5	2.4	1.7	2.0
Received but not consumed	2.5	1.7	2.4	0.9	2.0	3.5	1.3	3.5	2.1	3.3	2.0
Consumed one IFA per day	79.8	77.6	77.4	68.8	82.6	80.9	74.7	76.8	83.1	82.1	75.0
Received 100+ IFA tablets/syrup	86.2	88.1	80.5	90.4	77.9	85.3	78.2	83.7	88.7	78.3	83.5
Percentage of women who received full ¹ antenatal check-ups	78.4	84.5	75.5	84.4	72.7	78.7	72.1	76.6	83.1	75.9	76.2
Number of women	354	54	288	84	209	337	190	251	262	125	447

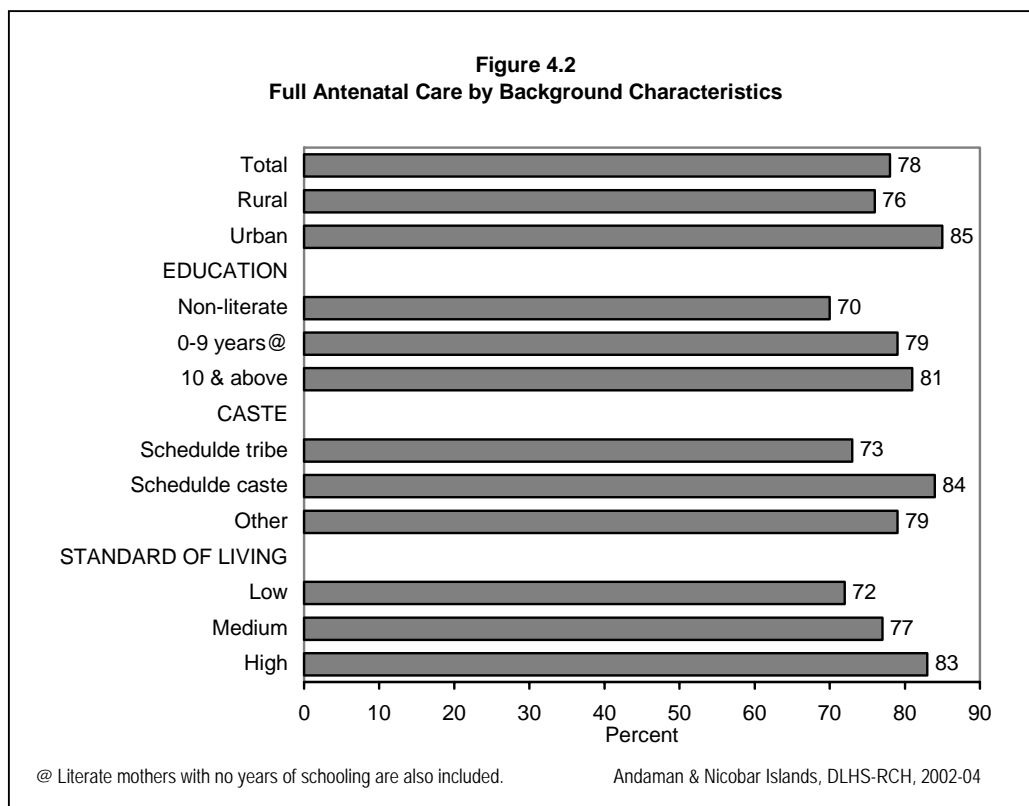
Note: Total includes 7 cases with other in religion and 21 cases with other backward class respectively in caste/tribe were not shown separately. ¹ At least three visits for antenatal check-ups, at least one TT injection received and was given adequate amount of IFA tablets/syrup. # Total figure may not add to N due to don't know and missing cases. ² Includes sub-centre, primary health centre, community health centre or referral hospital, government hospital, and government dispensary within the village.

The proportion of women who received at least four antenatal check-ups is slightly higher among Muslim and Hindu religions (each 93 percent) than among Christian religion (85 percent). Coverage is substantially lower for women from scheduled-tribes (85 percent) than to women of castes other than scheduled tribe (94-96 percent). Having four or more antenatal visits also increased with the standard of living - 87 percent for women with a low standard of living, 92 percent for women with a medium standard of living and 94 percent for women with a high standard of living. Availability of health facility in the village did not make any difference to the minimum four visits for antenatal check-ups.

Data on timing of first antenatal check-ups show that a slightly less than half of the women received their first antenatal check-up in the first trimester of pregnancy, and another half received their first check-up in the second trimester, and one percent of women received their first check-up in the third trimester. A relatively higher proportion of women in the urban areas (54 percent) as compared to those in rural areas (45 percent) had a check-up in the first trimester of pregnancy. Fifty-one percent of non-literate women had undergone their first antenatal check-up in the first trimester, and 50 percent of women who had completed at least 10 years of schooling received their first antenatal check-up in the first trimester. About half of the women with parity-1 and 48 percent of the women with parity-3 and above had undergone antenatal check-ups in first trimester. Muslim women were more likely to go for first antenatal check-ups in first trimester of their pregnancy as compared to Hindu and Christian women, and less than two-fifths of scheduled tribe women (38 percent) had visited in first trimester for first antenatal check-ups compared with 51 percent of scheduled caste women and 49 percent of women from other castes/tribes. Around 37 percent of women with low standard of living, 49 percent with medium standard of living and 51 percent of women with high standard of living had undergone their first antenatal check-ups in the first trimester of their pregnancy period.

Nutritional deficiencies in women are often exacerbated during pregnancy because of the additional nutrient requirements of foetal growth; therefore a pregnant woman needs six times more iron than a non-pregnant woman. The information on receiving iron folic acid tablets/syrup during pregnancy is also collected in the survey. Table 4.5 shows that women in Andaman & Nicobar Islands received IFA supplements for 79 percent of the last births during three years preceding the survey. The coverage of IFA tablets is relatively higher in urban areas (88 percent) than in rural areas (77 percent). IFA coverage is relatively less for scheduled caste women. Again, during pregnancy in the last three years preceding the survey, about 84 percent of women received 100 or more IFA, 82 percent in rural areas and 92 percent in urban areas. Intake of 100 or more IFA is positively associated with education and standard of living index, and also, with the availability of health facility in the village and negatively associated, in general, with parity. Lesser women from Christian religion and scheduled tribes received 100 or more IFA than their counterparts.

For the last live birth or still birth during the three years preceding the survey, women were asked whether they were given tetanus toxoid injection to prevent them and their babies from getting tetanus. Table 4.5 shows that 87 percent of the women received two or more tetanus toxoid injections. Coverage of two or more TT injections is slightly higher in urban areas (89 percent) than that in rural areas (86 percent). The coverage of at least one tetanus toxoid injection is more than 95 percent for women belonging to different categories of background characteristics.



The percentage of women who received full antenatal care, (that is, at least three antenatal check-ups, and at least one tetanus toxoid injection and supplementary iron in the form of IFA tablets daily for 100 days as recommended by the RCH programme,) has been presented in Figure 4.2. Around 78 percent of women in Andaman & Nicobar Islands received full antenatal care. Coverage of full antenatal care is relatively low for non-literate women, women with higher parity, Christian women, women from scheduled tribe and women with a low standard of living. Full antenatal coverage was also lower in rural areas (76 percent) than in urban areas (85 percent).

4.6 Antenatal Care Indicators by Districts

Table 4.6 shows the percentage of women who had given live/still birth during the three years preceding the survey and who received different types of antenatal care - the percentage who received antenatal check-up in the first trimester of pregnancy, the percentage who received at least three antenatal check-ups, the percentage who received at least one tetanus toxoid injection, the percentage given 100 or more iron folic acid tablets/syrup, and the percentage who received full antenatal care services - by districts.

Table 4.6 ANTENATAL CARE INDICATORS BY DISTRICT					
Percentage of women* who received different type of antenatal care by district, Andaman & Nicobar Islands, 2002-04					
District	Percentage that received an antenatal check-up in the first trimester of pregnancy	Percentage that received three or more antenatal check-ups	Percentage that received at least one tetanus toxoid injection	Percentage that received adequate amount of IFA ¹	Percentage that received full ² antenatal check-ups
Andamans	49.0	96.7	93.9	87.4	82.4
Nicobars	44.1	90.9	98.2	80.3	73.3
Andaman & Nicobar Islands	46.5	93.6	96.1	84.1	77.8

Note: * Women who had their last live/still birth since 1-1-1999/1-1-2001. ¹ 100 or more iron folic acid tablets including syrup. ² At least three visits for antenatal check-ups, at least one TT injection received and adequate amount of IFA.

The utilisation of antenatal care services differs in the two districts. A relatively higher proportion of the women from Andamans (49 percent) received their first antenatal check-up in the first trimester of pregnancy than those from Nicobars (44 percent). The percentage of women who received at least three visits for antenatal check-ups is comparatively more in Andamans (97 percent) than in Nicobars (91 percent). There has been good coverage of tetanus toxoid injections in the two districts – Andamans (94 percent) and Nicobars (98 percent). But on the other hand, performance regarding receipt of 100 or more IFA tablets/syrup is moderate. It is 87 percent in Andamans and 80 percent in Nicobars. The percentage of women who received full antenatal care is 82 percent in Andamans and 73 percent in Nicobars.

4.7 Pregnancy Complications and Treatment

Complications during pregnancy may affect both women's health and the outcome of the pregnancy adversely. Early detection of complications during pregnancy and their management are important components of the safe motherhood programme. In the survey, all the eligible women who had given their last live or still births during the three years preceding the survey were asked if at any time during the pregnancy, they had experienced any of the pregnancy-related problems such as swelling of hands and feet, paleness, visual disturbance, vaginal bleeding, convulsions, weak or no movement of foetus and abnormal position of foetus. All the information is based on women's self-reporting which is presented in Table 4.7 and Figure 4.3.

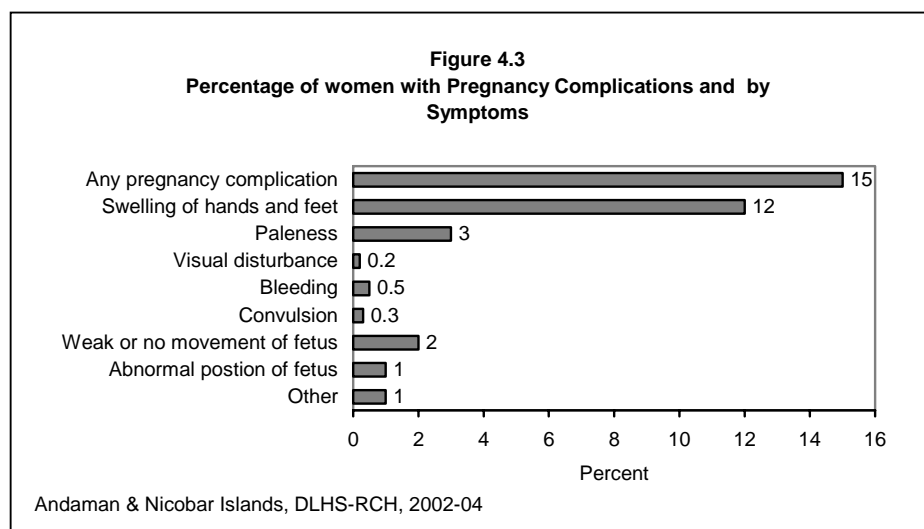


Table 4.7 PREGNANCY COMPLICATIONS

Percentage of women who had live/still births during three years preceding the survey by pregnancy complication and type of complication during pregnancy by some selected background characteristics, Andaman & Nicobar Islands, 2002-04

Background characteristic	Percentage of women with any pregnancy complication	Type of pregnancy complication;								Number of women
		Swelling of hands and feet	Paleness	Visual disturbances	Bleeding	Convulsion	Weak or no movement of foetus	Abnormal position of foetus	Other	
Age group (years)										
Less than 25 years	16.5	14.3	1.9	0.5	0.5	0.1	2.4	0.9	0.0	216
25-29	13.2	9.2	3.2	0.2	0.8	0.6	1.4	1.7	1.7	305
30-34	16.6	13.6	5.2	0.0	0.0	0.0	0.7	1.2	0.6	135
35+	(10.6)	(10.6)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	47
Children ever born										
1	16.8	14.6	3.8	0.3	0.2	0.0	2.4	1.0	0.2	274
2	14.8	10.3	2.5	0.4	0.8	0.9	1.0	2.1	1.8	254
3+	9.5	8.2	2.3	0.0	0.4	0.0	0.0	0.5	0.5	171
Residence										
Rural	14.9	11.9	3.1	0.3	0.6	0.4	1.0	1.4	0.9	572
Urban	12.8	9.9	2.1	0.0	0.0	0.0	3.6	0.7	0.6	131
Standard of living index										
Low	12.3	10.7	2.6	0.6	0.4	0.5	0.0	0.4	0.0	190
Medium	15.0	11.7	3.1	0.0	0.3	0.0	1.9	1.4	1.2	251
High	15.6	12.0	3.0	0.3	0.7	0.5	2.2	1.8	1.2	262
Received any ANC										
Yes	14.8	11.8	3.0	0.3	0.5	0.3	1.4	1.2	0.9	682
Total	14.5	11.6	2.9	0.2	0.5	0.3	1.5	1.3	0.9	703

Note: Total includes 4 women with zero parity and 21 cases with no category of received any antenatal checkups, which were not shown separately. @ Literate women with no years of schooling are also included. () based on less than 50 unweighted cases.

About 15 percent of the women experienced at least one pregnancy related problem. The proportion was slightly higher among rural women (15 percent) than among urban women (13 percent). Women aged 35 years and above, and women with higher parity face at least one pregnancy related problem less than younger women and women with low parity do. The major problems reported were 'swelling of hand and feet' (12 percent) and 'paleness' (3 percent). Around 2 percent reported weak or no movement of foetus, while 'abnormal position of foetus' was reported by one percent of the women. Other problems related to pregnancy were reported by less than one percent of women. Swelling of hands and feet, paleness and weak or no movement of fetus are relatively more among women with parity-1. There were not much differences in the proportion of women reporting other pregnancy related complications.

Women who reported at least one pregnancy related complication were asked whether they had consulted someone or had sought treatment for their problem and also, the source of treatment. Table 4.8 shows the percentage of women who had pregnancy complications and who obtained advice or had sought treatment by source of treatment according to residence and availability of health facility in the village. Around 72 percent of women reported that they had obtained advice or consulted someone for their problem.

Table 4.8 TREATMENT FOR PREGNANCY COMPLICATIONS					
Percentage of women* who had any pregnancy complication and sought treatment and source of treatment according to residence and availability of health facility in the village, Andaman & Nicobar Islands, 2002-04					
Treatment and source	Total	Residence		Availability of health facility ⁵ in the village	
		Rural	Urban	No	Yes
Percentage of women sought treatment who had any pregnancy complication	72.4	71.4	*	*	72.1
Number of women	102	85	17	15	70
Percentage sought treatment at health facility					
Government health facility ¹	93.1	94.6	*	*	94.8
Primary health centre	35.2	42.7	*	*	43.1
Sub centre	12.0	14.6	*	*	15.2
Private health facility ²	4.7	4.3	*	*	3.9
ISM ³ facility	1.7	0.5	*	*	0.6
Percent distribution of women who obtained treatment from					
Doctor	68.2	64.8	*	*	59.0
ANM/nurse/midwife/LHV	30.4	33.5	*	*	39.0
Other ⁴	1.4	1.7	*	*	2.0
Total percent	100.0	100.0	*	*	100.0
Number of women	74	61	13	10	51
Note: ¹ Include municipal hospital, dispensary, urban health centre/urban health post/urban family welfare centre, community health centre/rural hospital, primary health centre and sub centre. ² Include private hospital/clinic and non-governmental organization/trust hospital. ³ Either government or private Indian system of medicine. ⁴ Other includes Dai trained or untrained, other professional and ISM practitioner. ⁵ Includes sub-centre, primary health centre, community health centre or referral hospital, government hospital, and government dispensary within the village. * Percentage not shown – based on very few cases.					

Among women who sought treatment for pregnancy complications, 93 percent visited a government health facility including a primary health centre (35 percent) and sub-centre (12 percent). Only 5 percent of them visited a private health facility, and 2 percent had gone to a facility with the Indian system of medicine. Among women who sought treatment, 68 percent went to a doctor and 30 percent to an auxiliary nurse midwife or nurse or LHV.

4.8 Delivery Care

4.8.1 Place of Delivery

One of the important thrusts of the Reproductive and Child Health Programme is to encourage deliveries under proper hygienic conditions under the supervision of trained health professionals. The provision of delivery services in the government health institutions is one of the components of the RCH programme. For each live/still birth during three years preceding the survey, DLHS-RCH asked the women where (place) their children were born, who assisted during the deliveries in case of home deliveries, characteristics of deliveries and any problems that occurred during the delivery. Table 4.9 and Figure 4.4 present the place of delivery. Around 71 percent of the births took place in government health institutions and 5 percent in private health institutions, while one-fourth of births took place at home. More than four-fifths of the deliveries in urban areas and two-thirds of the deliveries in rural areas took place in health institutions. Deliveries in health facilities in Andaman & Nicobar Islands rose from 68 percent in Round-I to 76 percent in Round-II.

The proportion of births occurring in health institutions is higher for young women under 30 years (79 percent) than for women aged 30 years and above (65 percent). Institutional deliveries increase considerably with education and the standard of living. About 59 percent of the births to non-literate women and 82 percent births to literate women who had completed 10 or more years of schooling took place at health institutions. Women with a high standard of living were more likely to give birth in health institutions (84 percent) than women with a low standard of living (55 percent). The proportion of institutional deliveries decreases as parity increases from parity one (78 percent) to parity three and above (56 percent). Institutional deliveries are comparatively higher for Muslim (80 percent) and Hindu (79 percent) women than for Christian women (58 percent). Nearly 61 percent births of women from scheduled-tribes and 67 percent from scheduled castes are institutional deliveries as compared to 77 percent of births to women from the other castes/tribes. As expected, a higher proportion of births occurred through caesarean section (82 percent) took place at health institutions as compared to those of normal deliveries (70 percent). Among the deliveries that took place at home, none were through caesarean section. Availability of health facility in the villages did not increase the proportion of deliveries that took place at health institutions.

Table 4.9 PLACE OF DELIVERY					
Percent distribution of women who had given live/still births during three years preceding the survey, by place of delivery, according to selected background characteristics, Andaman & Nicobar Islands, 2002-04					
Background characteristics	Health institutions			Total percent	Number of women
	Public	Private	Home		
Age group (in years)					
Below 30	73.3	5.9	20.8	100.0	521
30 and above	62.3	2.6	35.1	100.0	181
Children ever born					
1	77.8	5.5	16.7	100.0	274
2	72.5	6.7	20.8	100.0	254
3+	55.8	1.2	43.0	100.0	171
Residence					
Rural	67.8	3.7	28.5	100.0	572
Urban	82.2	10.9	6.9	100.0	131
Education					
Non-literate	59.3	0.8	39.9	100.0	124
0-9@ years	67.5	4.4	28.1	100.0	362
10 years & above	81.9	8.5	9.6	100.0	216
Religion					
Hindu	78.6	6.2	15.2	100.0	354
Muslim	79.9	9.6	10.5	100.0	54
Christian	58.4	2.5	39.1	100.0	288
Caste#					
Scheduled caste	67.2	2.1	30.7	100.0	84
Scheduled tribe	61.0	2.5	36.6	100.0	209
Other	77.1	6.5	16.4	100.0	337
Standard of living index					
Low	54.9	1.1	44.0	100.0	190
Medium	68.8	4.3	26.9	100.0	251
High	83.5	8.5	8.0	100.0	262
Number of antenatal check-ups					
1-3	(66.7)	(2.8)	(30.6)	(100.0)	40
4+	71.8	5.1	23.1	100.0	642
Delivery characteristics					
Normal	70.1	3.7	26.2	100.0	633
Caesarean	81.5	18.5	0.0	100.0	56
Availability of health facility¹ in the village					
No	73.9	1.3	24.9	100.0	125
Yes	66.1	4.3	29.5	100.0	447
Total	70.5	5.0	24.5	100.0	703

Note: Total includes 4 women with zero parity, 7 cases with other in religion, 21 cases with other backward class in caste/tribe, 21 cases with no check-ups in number of antenatal check-ups and 15 cases with assisted in delivery characteristics were not shown separately. # Total figure may not add to N due to do not know and missing cases. @ Literate women with no years of schooling are also included. ¹ Includes sub-centre, primary health centre, community health centre or referral hospital, government hospital, and government dispensary within the village. () based on less than 50 unweighted cases.

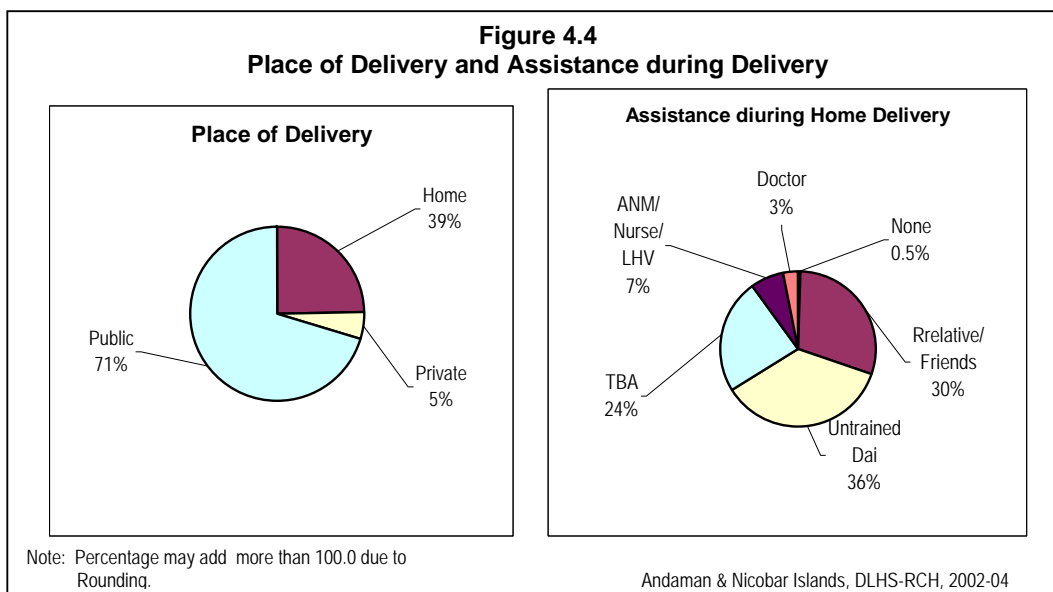
4.8.2 Assistance During Home Delivery

Table 4.10 shows distribution of women by assistance during home delivery by selected background characteristics. Generally, assistance during delivery can be provided by medical staff (doctors, ANM/nurse/LHV, TBA, un-trained *dai*), and relatives/friends. If more than one type of attendant assisted during the delivery, then only the most qualified person is considered. In the last three years only 3 percent of home deliveries were attended by doctors, 7 percent by ANM or nurse or LHV, 24 percent by trained birth attendants, 36 percent by untrained *dais* and 30 percent were attended by relatives and friends and less than one percent of home deliveries were not attended by anyone (Figure 4.4). Overall, health professionals attended 10 percent of deliveries that took place at home. The

percentage of births (home delivery) attended by health professionals is relatively more among young women under 30 years (12 percent) than among women aged 30 years and above (6 percent). The percentage of births attended by health professionals is relatively more among lower parity women. There were not much differences in the proportion of women reporting home deliveries that were attended by health professionals by other background characteristics of women.

Table 4.10 ASSISTANCE DURING HOME DELIVERY AND SAFE DELIVERY								
Percent distribution of women who had given live/still births during three years preceding the survey, by assistance during home delivery, and percentage of safe delivery, according to selected background characteristics, Andaman & Nicobar Islands, 2002-04								
Background characteristics	Attendant assisting during home delivery ¹						Number of women	Percentage of safe ² delivery
	Doctor	ANM/ Nurse/ LHV	TBA	Un- trained <i>dai</i>	Relative / friends	None		
Age group (in years)								
Below 30	4.2	7.9	15.8	39.2	32.9	0.0	108	81.7
30 and above	1.3	4.9	37.1	31.6	23.7	1.3	64	67.1
Children ever born								
1	(2.8)	(11.1)	(27.8)	(25.0)	(33.3)	(0.0)	46	85.0
2	6.7	10.1	30.0	30.8	22.5	0.0	53	82.7
3+	1.1	3.5	22.6	39.8	31.8	1.2	74	58.9
Residence								
Rural	3.3	6.0	24.4	34.7	31.1	0.5	163	74.1
Urban	*	*	*	*	*	*	9	94.5
Education								
Non-literate	3.7	6.7	8.5	42.4	38.6	0.0	50	64.3
0-9@ years	3.5	3.4	29.5	37.4	25.3	0.8	102	73.8
10 years & above	*	*	*	*	*	*	21	92.7
Religion								
Hindu	4.7	6.2	17.5	30.7	39.3	1.6	54	86.4
Muslim	*	*	*	*	*	*	6	90.2
Christian	2.5	7.1	26.0	38.1	26.3	0.0	113	64.7
Caste#								
Scheduled caste	(0.0)	(6.7)	(33.3)	(26.7)	(33.3)	(0.0)	26	70.1
Scheduled tribe	3.7	9.6	17.9	33.8	35.0	0.0	76	68.3
Other	4.6	6.0	20.2	36.2	31.4	1.6	55	85.4
Standard of living index								
Low	4.2	2.7	19.4	37.5	35.2	1.0	83	59.0
Medium	2.7	4.9	20.9	41.1	30.4	0.0	68	75.1
High	*	*	*	*	*	*	21	94.3
Number of antenatal check-ups								
1-3	*	*	*	*	*	*	15	(75.0)
4+	2.3	6.6	26.0	35.6	29.5	0.0	148	78.9
Delivery characteristics								
Normal	0.0	7.0	24.0	37.8	30.6	0.5	166	75.6
Caesarean	*	*	*	*	*	*	0	100.0
Availability of health facility³ in the village								
No	(14.3)	(17.9)	(28.6)	(17.9)	(21.4)	(0.0)	31	83.0
Yes	0.0	4.0	24.6	39.1	31.6	0.6	132	71.6
Total	3.1	6.8	23.7	36.4	29.5	0.5	172	77.9

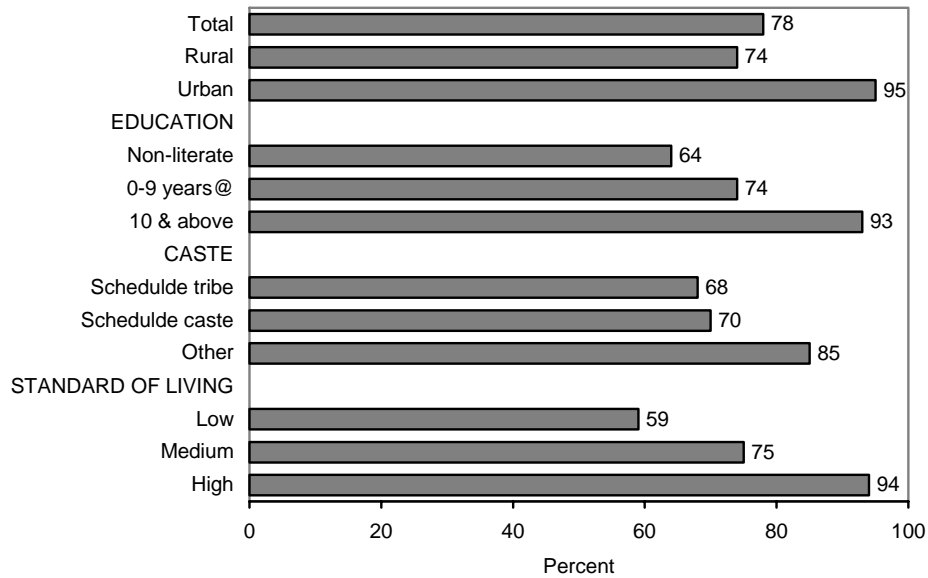
Note: Total includes 4 women with zero parity, 7 cases with other in religion, 21 cases with other backward class in caste/tribe, 21 cases with no check-ups in number of antenatal check-ups and 15 cases with assisted in delivery characteristics were not shown separately. @ Literate women with no years of schooling are also included. # Total figure may not add to N due to do not know and missing cases. ¹ If the respondent mentioned more than one attendant, only the most qualified attendant is shown. ² Either institutional delivery or home delivery assisted by doctor/ANM/Nurse/LHV. ³ Includes sub-centre, primary health centre, community health centre or referral hospital, government hospital, and government dispensary within the village. () Based on less than 50 unweighted cases. * Percentage not shown – based on very few cases.



4.8.3 Delivery Assisted by Skilled Persons

The extent of safe deliveries varied substantially by background characteristics of women (Table 4.10 and Figure 4.5). Around 78 percent of the births were considered to be safe in Andaman & Nicobar Islands. In urban areas, 95 percent of the deliveries were safe as against 74 percent in rural areas. About 82 percent of the deliveries were safe for younger women aged below 30 as compared to 67 percent for elderly women. The proportion of safe deliveries was comparatively higher among Muslim (90 percent) and Hindu (86 percent) women than among Christian women (65 percent). Around 68 percent of births to women from scheduled-tribes and 70 percent to women from scheduled castes were considered to be safe deliveries, compared to 85 percent of births to women from other castes/tribes. Proportion of safe deliveries decreases from 85 percent to 59 percent as parity rises from 1 to 3 and above. The proportion of safe deliveries increased considerably with women's education and standard of living. Around 64 percent of non-literate women had safe deliveries whereas its prevalence is 93 percent among women who had completed at least high school. Women with a high standard of living had 94 percent safe deliveries compared to 75 percent of women with a medium standard of living and 59 percent with a low standard of living. Only 76 percent of women with normal deliveries had safe deliveries. The proportion of safe deliveries was surprisingly lower in villages with a health facility (72 percent) than to women from those villages where health facilities are not available (83 percent).

Figure 4.5
Delivery Assisted by Skilled Persons by Background Characteristics



Andaman & Nicobar Islands, DLHS-RCH, 2002-04

@ Literate Women with no years of Schooling are also included.

4.9 Reasons for Not Going to Health Institutions for Delivery

Table 4.11 shows the percentage distribution of women who did not deliver in health institutions in the three years preceding the survey by reasons. The main reason for not going to health institutions has been presented according to residence and availability of health facility in the village. Around one-fifth of the women stated that they did not go to health institutions for delivery as the services are of poor quality. About 18 percent of the women reported that they had no time to go to the health institutions and 17 percent felt that they get better care at home. Other factors contributing for not going to health institutions for delivery were, 'no transportation or health facility is too far' and 'family did not allow' (each 11 percent), 'not necessary' (9 percent), 'it costs too much' (8 percent) and 'lack of knowledge' and 'not customary' (each 3 percent).

Table 4.11 REASONS FOR NOT GOING TO HEALTH INSTITUTIONS FOR DELIVERY					
Percent distribution of women who had given last live/still birth at home during three years preceding the survey by the main reason for not going to health institution for delivery, according to residence and availability of health facility in the village, Andaman & Nicobar Islands, 2002-04					
Reason	Total	Residence		Availability of health facility ¹ in the village	
		Rural	Urban	No	Yes
Not Necessary	9.2	9.2	*	(7.1)	10.2
Not customary	2.6	2.7	*	(0.0)	3.3
Cost too much	8.4	8.2	*	(3.6)	9.6
Health facility too far/ No transport	11.4	12.1	*	(10.7)	11.9
Poor quality service	19.6	19.4	*	(32.1)	16.4
No time to go	18.4	19.5	*	(21.4)	18.7
Family did not allow	10.5	9.2	*	(0.0)	11.3
Better care at home	16.5	16.8	*	(17.9)	16.2
Lack of knowledge	2.9	2.4	*	(3.6)	2.3
Other	0.5	0.5	*	(3.6)	0.0
Total percent	100.0	100.0	*	(100.0)	100.0
Number of women	172	163	9	31	132

Note: ¹ Includes sub-centre, primary health centre, community health centre or referral hospital, government hospital, and government dispensary within the village. * Percentage not shown – based on very few cases. () based on less than 50 unweighted cases.

4.10 Delivery Characteristics by Districts

Table 4.12 shows the delivery characteristics by district; institutional delivery (delivery in government or private health institutions), home delivery and skilled persons' assistance during home delivery and safe deliveries for last live/still births to women during the three years preceding the survey. The proportion of institutional deliveries is comparatively lower in Nicobars (72 percent) than in Andamans (79 percent).

Table 4.12 DELIVERY CHARACTERISTICS BY DISTRICT				
Place of delivery, assistance during home deliveries, and percentage of safe deliveries by district, Andaman & Nicobar Islands, 2002-04				
Districts	Percentage of women who had institutional delivery	Percentage of women who had delivery at home	Home delivery assisted by skilled ¹ persons	Percentage of safe ² delivery
Andamans	78.6	21.4	8.8	80.5
Nicobars	71.8	28.2	10.9	74.9
Andaman & Nicobar Islands	75.5	24.5	9.9	77.9

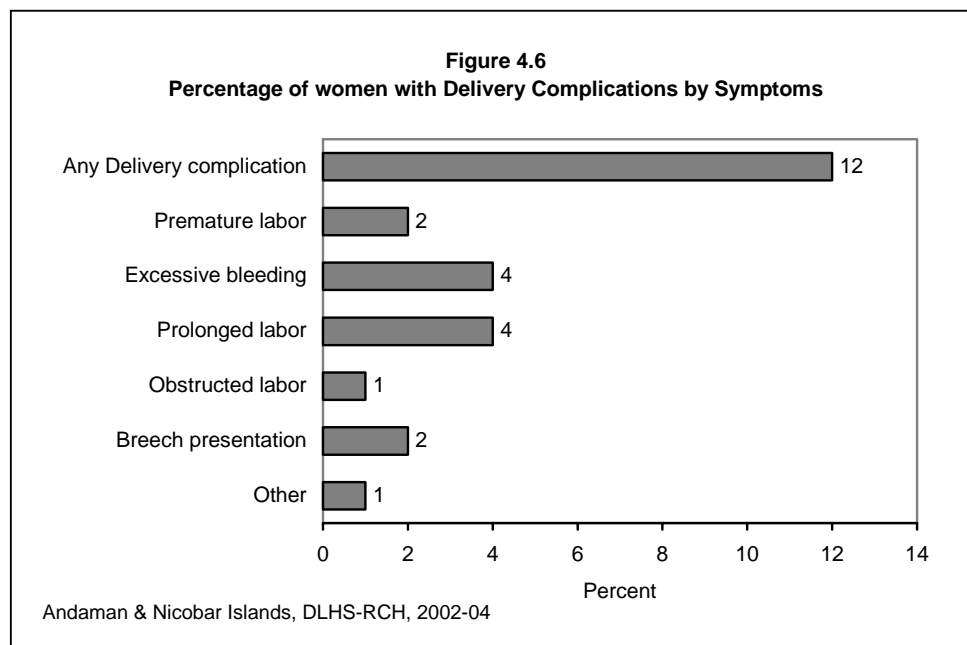
Note: ¹ Includes Doctor/ANM/Nurse. ² Either institutional delivery or home delivery assisted by skilled person.

Nearly 21 percent of the births in Andamans and 28 percent in Nicobars took place at home. Only around one-tenth of home deliveries in both the districts were attended by a health professional. The proportion of safe deliveries is relatively more in Andamans (81 percent) than in Nicobars (75 percent).

4.11 Complications During Delivery

Complications during delivery include ‘premature labour’, ‘obstructed labour’, ‘prolonged labour (more than 12 hours)’, ‘breech presentation’, ‘excessive bleeding during delivery’ and ‘other problems’ at the time of delivery reported by women during the three years preceding the survey. Slightly more than one-tenth of the women experienced at least one problem during delivery (Table 4.13 and Figure 4.6). The proportion of delivery complications is marginally higher among urban women (14 percent) than among rural women (12 percent). Younger women below the age of 30 years, reported relatively more of at least one delivery related problem than older women aged 30 years and above. The percentage reporting at least one delivery related problem was more among women with low parity 1-2 than among women with higher parity. Among women who had caesarean deliveries, 58 percent reported experiencing such problems, and 8 percent women with normal deliveries also cited complications during delivery. A higher proportion of women who delivered in health institutions (13-44 percent) faced at least one delivery complication compared to those who delivered at home (3 percent).

Table 4.13 DELIVERY COMPLICATIONS								
Percentage of women who had given last live/still births during three years preceding the survey by delivery complication, according to selected background characteristics, Andaman & Nicobar Islands, 2002-04								
Background characteristic	Any delivery complication	Type of delivery complication;						Number of women
		Premature labour	Excessive bleeding	Prolonged labour	Obstructed labour	Breech presentation	Other	
Age group (in years)								
Below 30	13.6	2.6	4.9	4.0	1.0	1.9	1.5	521
30 and above	7.4	0.4	1.3	3.0	2.5	0.4	0.6	181
Children ever born								
1	16.4	2.8	4.7	6.4	1.7	2.7	2.1	274
2	11.4	2.2	5.3	1.6	1.4	0.7	0.6	254
3+	4.4	0.5	0.2	1.8	0.9	0.9	1.0	171
Residence								
Rural	11.6	1.7	4.2	3.9	1.2	1.5	1.2	572
Urban	13.5	3.1	3.0	3.2	2.1	1.3	1.5	131
Number of antenatal check-ups								
1-3	(11.1)	(2.8)	(2.8)	(2.8)	(2.8)	(0.0)	(0.0)	40
4+	12.3	2.0	3.9	4.0	1.4	1.6	1.3	642
Delivery characteristics								
Normal	7.5	2.0	2.4	2.9	0.5	0.6	0.8	633
Caesarean	58.0	2.1	20.0	9.3	11.8	11.3	6.3	56
Place of delivery								
Government sector	12.8 (43.9)	1.9 (17.1)	4.1 (9.8)	3.9 (12.2)	1.3 (7.3)	2.1 (2.4)	1.6 (7.3)	495 35
Private	2.7	0.0	1.7	1.4	0.0	0.0	0.0	172
Home	12.0	2.0	3.9	3.8	1.4	1.5	1.3	703
Total								
Note: Total includes 4 women with zero parity, 21 cases with no check-ups in number of antenatal check-ups, 15 cases with assisted in delivery characteristics were not shown separately. () based on less than 50 unweighted cases.								



The major problems reported were ‘excessive bleeding’ and prolonged labour’ (each 4 percent), ‘premature labour’ and ‘breach presentation’ (each 2 percent) and one percent each reported ‘obstructed labour’ and ‘other’ problems related to delivery. The age and rural-urban differences in the proportions of women reporting all these problems are marginal. Except premature labour, all other complications were more among women who had a caesarean section. Women whose recent delivery was performed in medical institutions were more likely to report all the problems compared with those reporting home deliveries.

4.12 Post-delivery Complications and Treatment

Table 4.14 and Figure 4.7 present information about women who faced complications after delivery according to some selected background characteristics. The incidence of post-delivery complications judged by any of the following during the first six-weeks of delivery- ‘high fever’, ‘lower abdominal pain’, ‘foul smelling vaginal discharge’, ‘excessive bleeding’, ‘convulsions’, ‘severe headache’, and ‘other problems’. Around 7 percent of women reported that they faced any of these problems during the first six weeks after their delivery. The proportion of women who cited at least one post-delivery complication is marginally higher in rural areas (8 percent) than in urban areas (7 percent). Younger women aged below 30 years, women who had their deliveries with caesarean section and women whose deliveries at home were assisted by TBA or untrained Dai are more prone to report at least one post-delivery related problem.

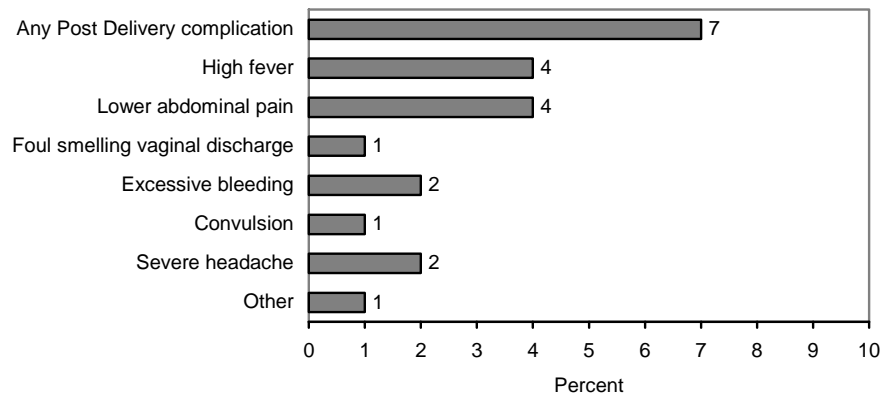
Table 4.14 POST DELIVERY COMPLICATIONS

Percentage of women who had given last live/still births during three years preceding the survey by post delivery complication, according to selected background characteristics, Andaman & Nicobar Islands, 2002-04

Background characteristic	Any post delivery complication	Type of post delivery complication;							Number of women
		High fever	Lower abdominal pain	Foul smelling vaginal discharge	Excessive bleeding	Convulsion	Severe headache	Other	
Age									
Below 30	8.2	4.5	3.5	0.8	2.0	0.6	2.6	0.8	521
30 and above	5.4	1.4	4.5	0.0	0.0	0.0	0.0	0.0	181
Children ever born									
1	7.8	4.1	3.7	0.8	1.5	0.6	2.7	1.5	274
2	6.2	3.1	2.7	0.0	1.6	0.3	1.0	0.0	254
3+	8.2	3.4	4.8	0.5	0.5	0.0	1.3	0.0	171
Residence									
Rural	7.6	3.7	3.9	0.2	1.4	0.4	1.8	0.7	572
Urban	6.7	3.8	3.0	2.3	1.5	0.8	2.3	0.0	131
Delivery characteristics									
Normal	6.4	2.9	3.6	0.5	1.3	0.5	1.4	0.6	633
Caesarean	16.4	11.4	4.4	0.0	3.1	0.0	5.8	0.0	56
Place of delivery									
Government sector	7.5	4.4	2.7	0.6	1.4	0.3	2.0	0.8	495
Private	(4.9)	(2.0)	(1.0)	(1.0)	(1.0)	(1.0)	(2.0)	(0.0)	35
Home	7.6	1.3	6.8	0.0	1.2	0.4	1.0	0.0	172
Assistance during home delivery									
TBA	(17.1)	(5.7)	(14.3)	(0.0)	(5.7)	(2.9)	(5.7)	(0.0)	41
Untrained dai	12.6	1.4	12.6	0.0	0.0	0.0	0.0	0.0	63
Relative/friends	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	51
Total	7.4	3.7	3.8	0.6	1.5	0.5	1.9	0.6	703

Note: Total includes 4 women with zero parity, 15 cases with assisted in delivery characteristics, 5, 12 and 1 case with doctor, ANM and none respectively in assistance during home delivery were not shown separately. () based on less than 50 unweighted cases.

Figure 4.7
Percentage of women with Post Delivery Complications by Symptoms



Andaman & Nicobar Islands, DLHS-RCH, 2002-04

Women reported high fever and lower abdominal pain (each 4 percent), severe headache and excessive vaginal bleeding (each 2 percent) and foul smelling vaginal discharge, convulsions and other problems (each less than one percent). Rural-urban differences in all symptoms of postpartum complications are not large. All the postpartum complications, except lower abdominal pain, are reported more among younger women aged below 30 years. There are differences in the likelihood of having different symptoms in the postpartum period by place of delivery, assistance during delivery and type of delivery.

Women who reported at least one complication during the postpartum period were asked, whether they had consulted or sought treatment for their problems and also, the source of treatment. Table 4.15 shows the percentage of women who had post delivery complications and who sought treatment by source of treatment according to residence and availability of health facility in the village. Around 81 percent of women reported that they had obtained advice or had consulted someone for their problems.

Table 4.15 TREATMENT FOR POST DELIVERY COMPLICATIONS					
Percentage of women who had last live/still births during three years preceding the survey and who had any post delivery complication, sought treatment for the problems, and source of treatment according to residence and availability of health facility in the village, Andaman & Nicobar Islands, 2002-04					
Treatment and source	Total	Residence		Availability of health facility ⁴ in the village	
		Rural	Urban	No	Yes
Percentage of women sought treatment who had any post delivery complication	81.2	(78.3)	*	*	(73.3)
Number of women	52	44	9	15	29
Percentage sought treatment at health facility					
Government health facility ¹	(92.9)	(97.2)	*	*	*
Primary health centre	(9.5)	(11.1)	*	*	*
Sub centre	(7.1)	(8.3)	*	*	*
Private health facility ²	(7.1)	(5.6)	*	*	*
ISM ³ facility	(2.4)	(0.0)	*	*	*
Percent distribution of women who obtained treatment from					
Doctor	(90.5)	(91.7)	*	*	*
ANM/nurse/midwife/LHV	(9.5)	(8.3)	*	*	*
Total percent	(100.0)	(100.0)	*	*	*
Number of women	42	37	6	13	23
Note: ¹ Include municipal hospital, dispensary, urban health centre/urban health post/urban family welfare centre, community health centre/rural hospital, primary health centre and sub centre. ² Include private hospital/clinic and non-governmental organization/trust hospital. ³ Either government or private Indian system of medicine. ⁴ Includes sub-centre, primary health centre, community health centre or referral hospital, government hospital, and government dispensary within the village. * Percentage not shown – based on very few cases. () based on less than 50 unweighted cases.					

Among women who sought treatment for complications in the postpartum period, most of them visited a government health facility including primary health centre and sub-centre. Most of the women who sought treatment (nine-tenths) preferred to go to a doctor and less than one-tenth visited an auxiliary nurse midwife or nurse or LHV.

4.13 Obstetric Morbidity by Districts

The extent of health problems/ complications women suffer during pregnancy, delivery and post-delivery periods indicates the state of obstetric morbidity. Table 4.16 presents the incidence of pregnancy, delivery and post-delivery complications and treatment seeking behaviour in case of pregnancy and post-delivery complications by district. As mentioned earlier, in the union territory, 15 percent, 12 percent and 7 percent of the women experienced pregnancy, delivery and post-delivery complications respectively. About 72 percent of the women sought treatment for pregnancy complications and 81 percent for post-delivery complications.

Table 4.16 PREGNANCY, DELIVERY AND POST DELIVERY COMPLICATIONS					
Extent of pregnancy, delivery and post delivery complications and treatment seeking behaviour by districts, Andaman & Nicobar Islands, 2002-04					
District	Percentage of women ¹				
	Who had complication during pregnancy	Sought treatment for pregnancy complication ²	Who had delivery complication	Who had post delivery complication	Sought treatment for post delivery complication ³
Andamans	20.2	71.5	16.6	11.2	76.4
Nicobars	8.9	77.5	7.1	(3.7)	(97.6)
Andaman & Nicobar Islands	14.5	72.4	12.0	7.4	81.2

Note: ¹ Women who had last live/still birth during three years preceding the survey. ² Women who reported at least one complication of pregnancy. ³ Women who reported at least one post delivery complication. () Based on less number of cases.

The incidence of pregnancy complications is higher in Andamans (20 percent) than in Nicobars (9 percent). The percentage of women who experienced at least one type of delivery complication is more in Andamans (16 percent) than in Nicobars (7 percent) and incidence of post-delivery complications is also more in Andamans (11 percent) than in Nicobars (4 percent). The incidence of all the three types of complications seems to be linked with each other in varying proportions.

In both the districts of Andaman & Nicobar Islands more than nine-tenths of the women received some kind of antenatal care. Thus, a large proportion of women in these districts were having contact with a doctor or any other health workers during the antenatal period, and more than 70 percent of the women sought treatment for pregnancy complications. Similarly, among women who experienced at least one symptom of postpartum complications, the proportion seeking treatment was more than three-fourths in the two districts.

CHAPTER V

CHILD CARE AND IMMUNIZATION

Child health services under the Reproductive and Child Health (RCH) programme include health education to mothers on breast-feeding and services for immunization, Vitamin A supplements and Iron prophylaxis, treatment of diarrhoea and Acute Respiratory Infections (ARIs). The District Level Household Survey (DLHS) covered all the currently married women whose last surviving child was born during three years preceding the survey and information was obtained on those breastfeeding currently and duration of breastfeeding. They were also asked about their awareness of diarrhoea management and danger signs of pneumonia and practices followed in case of episodes of diarrhoea and ARI among the children. Data on immunization, administering Vitamin A supplements and Iron prophylaxis were collected for the last two living children born after January 1, 1999/2001. This chapter presents an analysis of the data collected on the above aspects.

5.1 Breastfeeding

Educating mothers on correct breastfeeding practices and child nutrition is one of the components of the RCH programme. Infant feeding practices have significant effects on the health of both mothers and children. Mothers are affected through the influence of breastfeeding on the period of postpartum infertility, and hence, on fertility levels and the length of birth intervals. These effects vary according to the duration and intensity of breastfeeding. Proper infant feeding, starting from the time of birth, is important for the physical and mental development of the child. Breastfeeding improves the nutritional status of young children and reduces morbidity and mortality. Breast milk not only provides important nutrients, but also protects the child against infection. The timing and type of supplementary foods introduced in an infant's diet have significant effects on the child's nutritional status.

As recommended by the World Health Organization (WHO), breastfeeding should be initiated immediately after birth and should be continued upto a minimum of six months. The WHO also suggests that the yellowish milk, known as colostrum, should be given to the baby because it provides protection against certain infections. Afterwards, it has to be supplemented with other semi-solid and solid foods at proper time intervals.

Table 5.1 and Figure 5.1 show the breastfeeding practices among children born during three years preceding the survey in Andaman & Nicobar Islands. Although, the practice of breastfeeding is common in Andaman & Nicobar Islands, the initiation of breastfeeding within two hours of the birth of the child is not always followed. About two-thirds of the children (66 percent) were breastfed within two hours of birth, and nine-tenths (89 percent) were breastfed within one day of birth (including those who were breastfed within two hours of birth), while 11 percent of children were breastfed after one day of birth. A little less than one-third of the women who gave birth to children during three years preceding the survey (31 percent) squeezed the first milk from the breast before they began breastfeeding. Not less than 60 percent of children in any socio-economic groups shown in Table 5.1 were breastfed within two hours of

birth, exception being scheduled caste children. Among the scheduled castes, 48 percent of children were breastfed within two hours of birth and 64 percent were breastfed within one day of birth. Around 73 percent of children from scheduled tribes were breastfed within two hours of birth, and 98 percent were breastfed within one day of birth. Women who have had high school education and above and those from households with high standard of living index are more likely to start breastfeeding their children early. There are minor differences in the proportion of children who were put to the breast after one day of birth by background characteristics of their mothers, exception being caste of the mothers.

Table 5.1 INITIATION OF BREASTFEEDING					
Percentage of children under age 3 years whose mothers started breastfeeding within two hours of birth, within one day of birth, and after one day of birth and percentage whose mothers squeezed the first milk from her breast before breastfeeding by selected background characteristics, Andaman & Nicobar Islands, 2002-04					
Background characteristic	Percentage started breastfeeding			Percentage whose mother squeezed first milk from breast	Number of children
	Within two hours of birth	Within one day of birth ¹	After one day of birth		
Residence					
Rural	66.7	88.4	11.1	31.7	433
Urban	60.1	91.3	8.7	28.2	98
Mother's education					
Non-literate	60.4	91.0	9.0	22.4	94
0-9@ years	63.4	87.2	12.3	32.7	271
10 and above	71.9	90.6	8.9	33.3	165
Religion					
Hindu	63.9	87.0	12.7	31.2	264
Muslim	(63.2)	(84.2)	(15.8)	(31.6)	36
Christian	68.2	91.4	7.9	32.1	224
Caste/tribe#					
Scheduled caste	47.8	64.3	35.7	35.1	50
Scheduled tribe	72.7	98.8	0.8	28.5	177
Other	63.1	90.0	9.4	27.8	248
Standard of living index					
Low	60.7	88.8	11.2	25.6	143
Medium	63.5	85.6	13.7	35.4	190
High	70.9	92.3	7.4	30.9	198
Total	65.5	89.0	10.6	31.1	531
Note: Table based on youngest living child born during the three years preceding the survey. Table includes 6 cases with other in religion and 15 cases with other backward class in caste/tribe, who were not shown separately. ¹ Includes children whose mother started breastfeeding within two hours of births. @ Literate mother with no years of schooling are included. #Total figure may not add to N due to do not know and missing cases. () based on less than 50 unweighted cases.					

The custom of squeezing the first milk from the breast before breastfeeding is widely practised in every group, but it is comparatively less among the mothers of children who live in rural areas, mothers of scheduled castes children, mothers who are literate and mothers of children who live in households with a medium or high standard of living.

Mothers of children born in three years preceding the survey were asked whether the children had been fed breast milk exclusively and if so, what the duration was. Here it needs to be mentioned that, exclusive breastfeeding includes breastfeeding the child without giving it anything including water. Results are shown in Table 5.2.

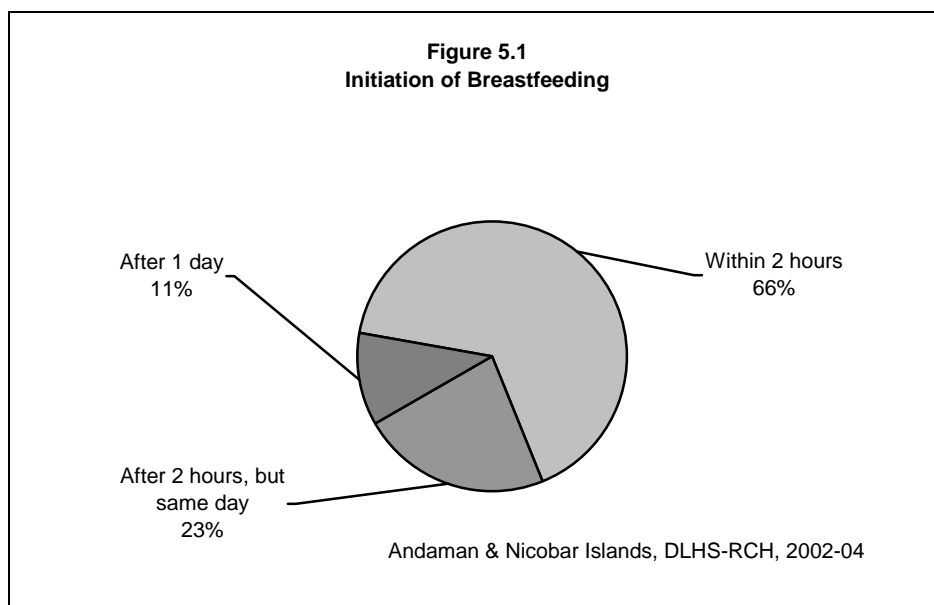


Table 5.2 EXCLUSIVE BREASTFEEDING BY CHILD'S AGE				
Percentage of children under age 3 years by exclusive breastfeeding and child's age in months, Andaman & Nicobar Islands, 2002-04				
Age in months	Status of exclusive breastfeeding			Number of children
	Exclusive breastfeeding	At least 4 months	At least 6 months	
<6	55.4	(80.2)	*	65
6-11	13.8	74.9	43.8	114
12-17	2.1	72.3	38.5	134
18-23	9.1	(69.5)	(45.7)	71
24-29	6.4	75.2	(43.3)	86
30-35	(4.5)	(78.3)	(68.8)	38
< 4 months	(61.2)	*	*	36
4-6 months	(38.7)	(66.9)	(19.2)	42
7-9 months	12.2	83.2	(52.2)	70

Note: Table based on youngest living child born during the three years preceding the survey. () based on less than 50 unweighted cases.

In Andaman & Nicobar Islands, nearly three-fifths of children under four months of age are exclusively breastfed. The percentage of infants exclusively breastfed drops steadily from 55 percent for children under 6 months of age to 14 percent for children who are 6-11 months old. About two-thirds of children in the age group 4-6 months were exclusively breastfed up to 4 months and a little more than half of children in the age group 7-9 months were exclusively breastfed up to 6 months.

5.1.1 Breastfeeding by Districts

Table 5.3 shows that in Andaman & Nicobar Islands, around 57 percent of the children in Andamans and 72 percent in Nicobars were put to the breast within two hours of birth. Around 18 percent of the children in Andamans and 5 percent in Nicobars were put to the breast after one day of birth. More than one-fourth of the mothers of children in Andamans (28 percent) and one-third in Nicobars (36 percent) squeezed the first milk before breastfeeding.

Table 5.3 BREASTFEEDING BY DISTRICT					
Percentage of children under age 3 years whose mothers started breastfeeding within two hours of birth, within one day of birth and after one day of birth, percentage whose mothers squeezed the first milk from her breast before breastfeeding and percentage of children who were exclusively breastfed by district, Andaman & Nicobar Islands, 2002-04					
District	Percentage started breastfeeding			Percentage whose mother squeezed first milk from breast	Exclusive breastfeeding ²
	Within two hours of birth	Within one day of birth ¹	After one day of birth		
Andamans	57.4	81.0	18.4	35.8	44.3
Nicobars	71.8	94.8	4.9	27.5	44.4
Andaman & Nicobar Islands	65.5	89.0	10.6	31.1	44.2

Note: Table based on youngest living child born during the three years preceding the survey. ¹ Includes children whose mother started breastfeeding within two hours of births. ² Based on youngest children age 6 months and older at the time of survey and breastfed exclusively 6 months or more as mother reported.

The extent of exclusive breastfeeding for six months is almost the same (44 percent) in the two districts.

5.2 Immunization of Children

The immunization of children against six serious but preventable diseases namely, tuberculosis, diphtheria, pertussis, tetanus, poliomyelitis and measles is the main component of the child survival programme. As part of the National Health Policy, the National Immunization Programme is being implemented on a priority basis. The Government of India initiated the Expanded Programme on Immunization (EPI) in 1978 with the objective of reducing morbidity, mortality and disabilities among children from six diseases.

The Universal Immunization Programme (UIP) was introduced in 1985-86 with the objective of covering at least 85 percent of all infants against the six vaccine preventable diseases by 1990. This scheme has been introduced in every district of the country. The standard immunization schedule developed for the child immunization programme specifies the age at which each vaccine should be administered and the number of doses to be given. Routine vaccinations received by infants and children are usually recorded on a vaccination card that is issued for the child.

In the first phase of Round II, all the women with last and last but one living child born after January 1, 1999 were asked whether the child/children had received the vaccination against polio at birth, tuberculosis (BCG), diphtheria, whooping cough (pertussis) and tetanus (DPT), polio and measles, and in the second phase, the reference period was from January 1, 2001. For Polio and DPT, further information on polio at birth and number of doses was asked. Children who received BCG, three doses of DPT and polio (excluding polio 0) and measles vaccinations are considered to be fully vaccinated. Information on the source of immunization for last dose and in case where immunization was not given, the reason for not giving immunization was also compiled.

Table 5.4 and Figures 5.2 and 5.3 present vaccination coverage rates for children in the age group 12-23 months. Only about 69 percent of the children are fully vaccinated, and one percent have not received any routine vaccination. Coverage of each vaccination is much higher than the percentage fully vaccinated. BCG, the first, second and third doses of DPT and Polio and measles vaccines have each been given to more than three-fourths of children (Figure 5.2). However, not all children who begin the DPT and polio vaccination series, go on to complete them. The difference between the percentage of children receiving the first and third doses is 9-percentage points for DPT and 8-percentage points for polio vaccination.

There has been a drop of 8-percentage points in full vaccination coverage in Andaman & Nicobar Islands since the time of Round I in 1998-99. These data indicate that despite the steps that have been taken to improve the immunization coverage for children in Andaman & Nicobar Islands, coverage levels are low and a sizeable proportion of children who received some early vaccinations dropped out of the programme before receiving all of the recommended vaccinations.

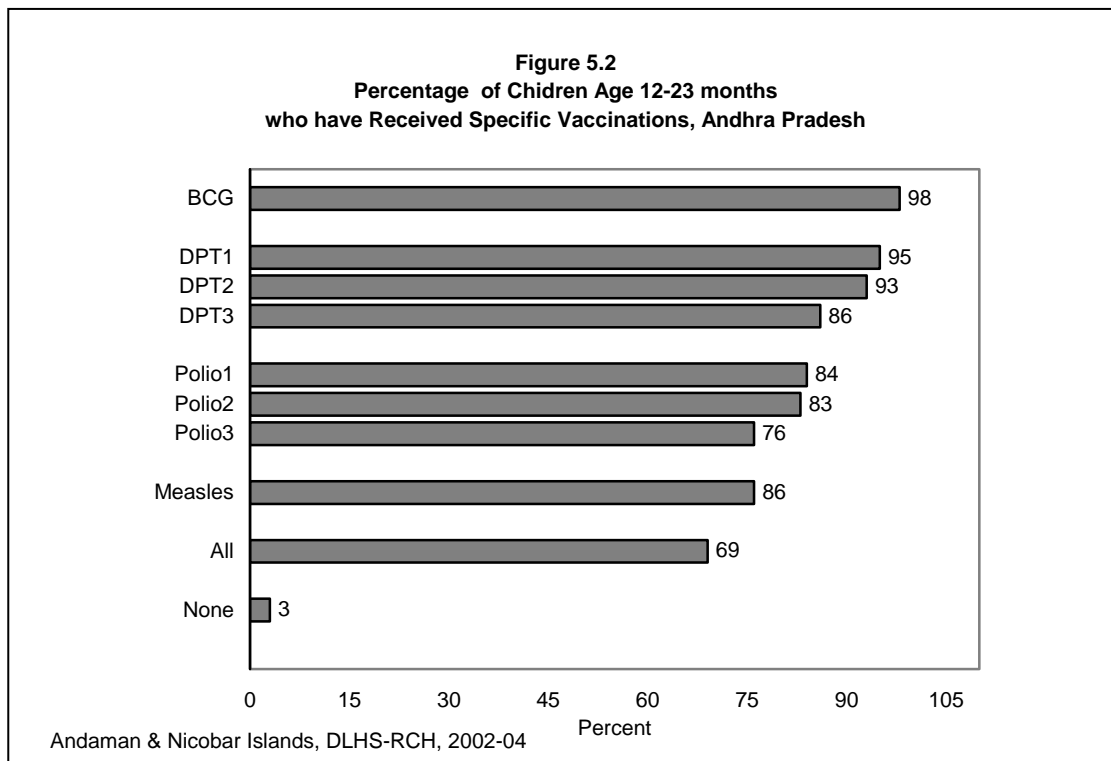
Table 5.4 VACCINATION OF CHILDREN

Percentage of children age 12-23 months who received vaccination according to some selected background characteristics, Andaman & Nicobar Islands, 2002-04

Background characteristic	Polio 0	BCG	DPT			Polio			Measles	Full ¹ vaccination	No vaccination	Number of children
			1	2	3	1	2	3				
Residence												
Rural	90.0	97.5	96.4	95.4	86.8	89.4	88.4	80.9	87.5	74.6	1.5	169
Urban	(100.0)	(100.0)	(90.2)	(85.4)	(80.5)	(63.4)	(61.0)	(53.7)	(78.0)	(46.3)	(0.0)	41
Sex of the child												
Male	93.5	97.1	96.3	93.9	83.9	85.0	83.5	74.4	89.4	71.2	1.6	125
Female	89.6	99.3	93.3	92.5	88.0	83.3	82.2	77.7	80.4	66.6	0.7	86
Birth order												
1	91.1	95.9	94.8	93.6	88.4	80.1	78.9	75.3	87.3	70.9	2.6	102
2	90.7	100.0	93.8	89.9	79.3	84.5	82.5	72.0	82.7	61.6	0.0	64
3	-	-	-	-	-	-	-	-	-	-	-	32
Mother's education												
Non-literate	(89.2)	(97.3)	(100.0)	(97.3)	(81.1)	(94.6)	(94.6)	(81.1)	(83.8)	(75.7)	(0.0)	40
0-9@ years	92.3	98.0	93.0	90.2	84.0	81.7	79.2	72.4	84.8	66.2	2.0	101
10 years and above	94.2	99.1	95.2	95.2	92.4	82.2	81.8	79.0	90.4	71.4	0.9	69
Religion												
Hindu	94.0	100.0	96.3	94.0	87.5	82.9	81.5	75.0	82.8	65.3	0.0	112
Other	89.6	95.7	93.8	92.5	83.4	85.9	84.7	76.6	89.0	73.9	2.7	98
Caste/tribe#												
Scheduled tribe	87.0	94.5	94.4	94.4	82.8	91.9	91.9	82.8	86.6	81.9	3.1	65
Other	95.9	100.0	95.7	92.3	84.5	81.0	78.3	69.8	84.9	62.6	0.0	101
Standard of living index												
Low	(87.8)	(92.7)	(95.1)	(92.7)	(80.5)	(90.2)	(90.2)	(82.9)	(87.8)	(75.6)	(4.9)	47
Medium	90.5	100.0	98.5	96.3	85.3	91.8	90.8	77.6	82.7	71.0	0.0	69
High	96.6	100.0	92.9	90.9	87.0	78.5	76.2	72.3	87.8	66.0	0.0	94
Total	91.9	98.0	95.1	93.3	85.6	84.3	83.0	75.7	85.7	69.3	1.2	210

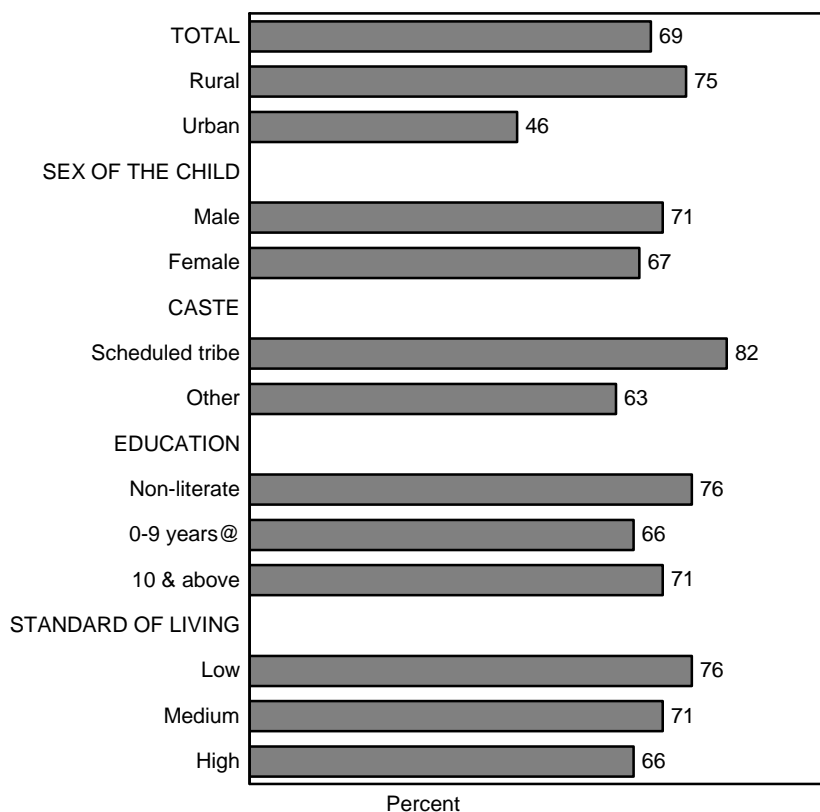
Note: Table includes only last and last but one living child born since 1.1.1999/1.1.2001. Total includes 12 cases with 4+ in birth order, 23 and 5 cases with scheduled caste and other backward class respectively in caste/tribe were not shown separately. @ Literate mothers with no years of schooling are included. # Total figure may not add to N due to do not and missing cases.¹ BCG, DPT and three doses of Polio (excluding Polio 0) and measles vaccines. () based on less than 50 unweighted cases.

The data indicates that the coverage of each type of vaccine is surprisingly less in urban areas than in rural areas. Less than half of the children in urban areas had received all the recommended vaccinations by the time of the survey, compared with three-fourths in rural areas. Differentials in rural-urban against polio 0 may be observed from the table. Nine-tenths of the children have received polio vaccine at the time of birth in rural areas, whereas all the children received the same in the urban areas.



Female children (67 percent) are slightly less likely than male children (71 percent) to be fully vaccinated. The women with birth order one are more likely than the women with birth order two to utilize child health care services. Children's vaccination coverage was lower among literate mothers than those who are non-literate. More than three-fourths of children of non-literate mothers are fully vaccinated compared to 66 percent of children with mothers' education below high school and 71 percent of mothers who have at least completed high school. Also, children from Scheduled tribes (82 percent) are more likely to be fully vaccinated as compared to those other than scheduled tribes (63 percent). The coverage of vaccination has declined with standard of living index of the households. More than three-fourths of children from households with a low standard of living are fully vaccinated, whereas only 66 percent of children are fully vaccinated from households with a high standard of living.

Figure 5.3
Percentage of Children Age 12-23 months who have
Received Specific Vaccinations, Andaman & Nicobar Islands



Andaman & Nicobar Islands, DLHS-RCH, 2002-04

@ Literate mothers with no years of schooling are also included.

Table 5.5 shows the percentage of children in the age group 12-23 months and 24-35 months for whom a vaccination card was shown to interviewers, and the percentage who received various vaccinations during the first year of life by place of residence. The interviewer was shown the vaccination card for almost the same proportion of children (70 percent) in the age group 12-23 months and 24-35 months.

The proportion of children fully vaccinated by age 12 months was relatively much higher (69 percent) for children in the age groups of 12-23 months than those in the age group of 24-35 months (51 percent). A rural-urban differential for the coverage of full vaccination is observed for children in both the age groups 12-23 and 24-35 months. Around three-fourths of children in the age group 12-23 months and three-fifths of children in the age group 24-35 months are fully vaccinated in rural areas, while the corresponding proportions are less than half and one-fifth in urban areas (Figure 5.4).

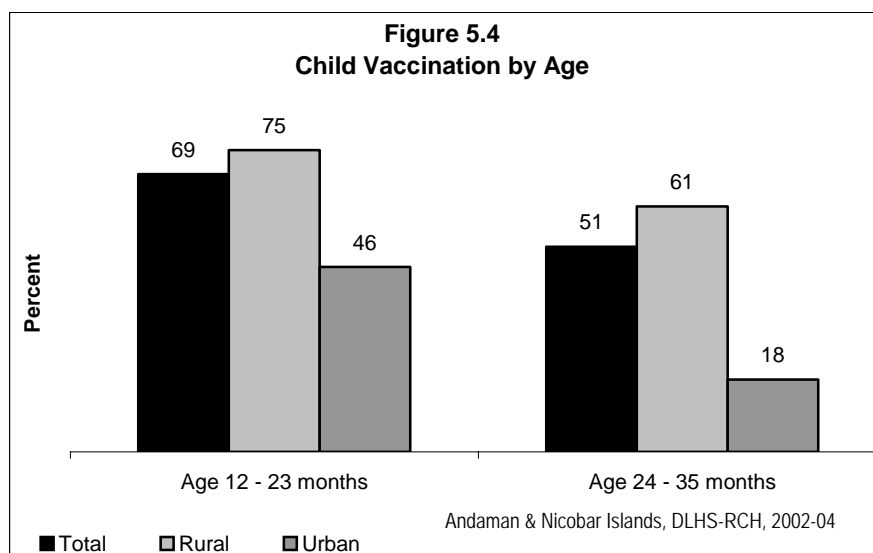
Table 5.5 CHILDHOOD VACCINATION RECEIVED BY 12 MONTHS OF AGE

Percentage of children age 12-23 months and 24-35 months with a vaccination card that shown to the interviewer and percentage who received specific vaccinations by 12 months of age according to residence, Andaman & Nicobar Islands, 2002-04

Vaccination status	Total		Rural		Urban	
	12-23 months	24-35 months	12-23 months	24-35 months	12-23 months	24-35 months
Vaccination card shown to interviewer	70.1	69.7	68.5	67.4	(75.6)	(77.3)
Percentage vaccinated by 12 months of age						
Polio 0	91.9	88.2	90.0	87.8	(100.0)	(90.9)
BCG	98.0	97.3	97.5	99.0	(100.0)	(93.2)
Polio doses						
No Polio	2.9	3.5	2.9	1.2	(3.0)	(15.8)
1	1.4	1.4	1.0	1.7	(3.0)	(0.0)
2	7.9	7.2	8.0	7.7	(9.1)	(5.3)
3	82.7	78.0	86.0	83.3	(66.7)	(47.4)
Don't remember	5.0	9.9	2.2	6.1	(18.2)	(31.6)
DPT injection						
No DPT	1.7	2.9	1.5	1.5	(2.4)	(6.8)
1	1.8	0.6	1.0	0.7	(4.9)	(0.0)
2	7.7	5.6	8.6	6.7	(4.9)	(2.3)
3	85.6	87.2	86.8	88.1	(80.5)	(84.1)
Don't remember/missing	3.2	3.9	2.1	2.9	(7.3)	(6.8)
Measles	85.7	91.0	87.5	91.1	(78.0)	(90.9)
Full ¹ vaccination	69.3	50.9	74.6	61.1	(46.3)	(18.2)
No vaccination at all	1.2	1.2	1.5	1.0	(0.0)	(2.3)
Number of children	210	185	169	140	41	45

Note: Table includes only last and last but one living child born since 1.1.1999/1.1.2001. ¹ BCG, three injection of DPT, three doses of Polio (excluding Polio 0) and measles vaccinations. () based on less than 50 unweighted cases.

Error!



5.3 Source of Immunization

Table 5.6 gives the percent distribution of children under three years of age who have received any vaccination by the source of last vaccine, according to place of residence and availability of health facilities in the village. Most of the children (97 percent) in Andaman & Nicobar Islands were immunized at the government health facilities and only 2 percent at private health facilities. The community/primary health centre, sub-centre and Government/Municipal hospital are the major providers of childhood vaccinations. Among the children immunized, 43 percent of them had received vaccinations from community health centre or from primary health centre, 24 percent from government/municipal hospital and 29 percent had received vaccinations from sub-centre. The percentage of children receiving vaccination from the private sector is relatively higher in urban areas (6 percent) than in rural areas (less than one percent). More or less the same proportion of children from those villages where health facilities are available and from those villages with no such health facilities had received vaccinations from the government health facilities.

Table 5.6 SOURCE OF CHILDHOOD VACCINATION					
Percent distribution of children under age 3 years who have received any vaccination by source of last vaccination, according to place of residence and availability of health facilities in the village, Andaman & Nicobar Islands, 2002-04					
Source of vaccination	Total	Residence		Availability of health facility ¹ in the village	
		Rural	Urban	No	Yes
Government health sector					
Government/municipal hospital	24.4	16.9	55.5	20.4	15.8
Community/primary health centre	43.1	49.7	15.5	39.6	52.9
Sub-centre	28.9	31.9	16.5	38.7	29.8
RCH/MCP camp	0.2	0.3	0.0	1.3	0.0
Private health sector					
Private hospital	1.1	0.7	2.8	0.0	0.9
Private doctor	0.7	0.0	3.6	0.0	0.0
ISM ² health facility	0.1	0.1	0.0	0.0	0.1
Other	0.6	0.2	2.2	0.0	0.3
Do not remember	0.2	0.0	1.0	0.0	0.0
Missing	0.8	0.3	3.1	0.0	0.3
Total percent	100.0	100.0	100.0	100.0	100.0
Number of children	551	444	107	106	339
Note: Table includes last and last but one living children born in the three years preceding the survey. ¹ Includes sub-centre, primary health centre, Community health centre or referral hospital, government hospital, and government dispensary within the village. ² Either government or private health facility of Indian System of Medicine.					

5.4 Vitamin A and IFA Supplements

Vitamin A deficiency is one of the most common nutritional deficiency disorders in the world, affecting more than 250 million children worldwide (Bolem et. al., 1997). The child survival programme also includes administration of five doses of Vitamin A for prevention of night blindness and distribution of IFA for iron supplement. In Round II, mothers of children born during three years before the survey were asked whether their children had received a dose of Vitamin A and IFA tablets/syrup. Those who said that their children had received a dose of Vitamin A and IFA tablets/syrup were further asked how many doses were given. Table 5.7 shows the percentage of children in the age group 12-35 months who received at least one dose of Vitamin A and IFA tablets/syrup by selected background characteristics. In the union territory of Andaman & Nicobar Islands as a whole, more than three-fourths of the children (78 percent) received at least one dose of Vitamin A, however, only 2 percent of the children received IFA tablets/syrup. This indicates that a large number of children in Andaman & Nicobar Islands received Vitamin A supplements, but a very few children received IFA tablets/syrup supplementation.

There are marginal differences in the proportion of children who had received at least one dose of Vitamin A by age, sex and birth order of children. A comparatively higher proportion of children living in rural areas received at least one dose of Vitamin A than urban areas. However, there is a positive relationship between mothers' educational level and household standard of living, though marginal, and the receipt of a dose of Vitamin A. Children from other religions are less likely than children of Hindu religion to receive any dose of vitamin A. Also, children from schedule tribes are less likely to receive at least one dose of Vitamin A than children from scheduled castes or other castes/tribes. More or less similar pattern is observed for the receipt of IFA tablets/syrup.

Table 5.7 VITAMIN A AND IFA SUPPLEMENTATION FOR CHILDREN			
Percentage of children age 12-35 months who have received at least one dose of Vitamin A and iron folic acid tablets/syrup, according to selected background characteristics, Andaman & Nicobar Islands, 2002-04			
Background characteristic	Percentage who received at least one dose of vitamin A	Percentage who received iron folic acid tablets/syrup	Number of children
Age of the child			
12-23 months	76.7	3.0	210
24-35 months	78.6	1.1	185
Sex of the child			
Male	78.3	2.0	219
Female	76.7	2.3	176
Birth order			
1	78.4	1.2	174
2	79.4	3.2	138
3	76.0	3.3	59
Residence			
Rural	79.0	1.9	309
Urban	72.8	3.1	86
Mother's education			
Non-literate	69.4	2.3	77
0-9 years@	74.6	1.2	187
10 years and above	86.8	3.3	131
Religion			
Hindu	80.2	2.5	218
Other	74.4	1.8	177
Caste/tribe #			
Scheduled caste	(86.1)	(8.3)	37
Scheduled tribe	73.8	1.3	116
Other	78.9	1.5	203
Standard of living index			
Low	73.7	1.1	102
Medium	76.7	3.1	132
High	80.8	2.0	161
Availability of health facility in the village¹			
Yes	78.4	2.0	239
No	80.8	1.6	70
Total	77.6	2.2	395
<p>Note: Table includes last and last but one living children born in the three years preceding the survey. Total includes 23 cases with 4+ in birth order, 11 cases with other backward class in caste/tribe were not shown separately. @ Literate mother with no years of schooling are also included here. # Total figure may not add to N due to do not know and missing cases. ¹ Includes sub-centre, primary health centre, Community health centre or referral hospital, government hospital, and government dispensary within the village. () based on less than 50 unweighted cases.</p>			

5.5 Immunization Coverage by Districts

The coverage of vaccination rates for all vaccines for children in the age group 12-23 months in the two districts is presented in Table 5.8.

Table 5.8 CHILDHOOD VACCINATION BY DISTRICT								
Percentage of children who received specific vaccinations and Vitamin A supplementation by district, Andaman & Nicobar Islands, 2002-04								
District	Percentage vaccinated ¹							Percentage received at least one dose of Vitamin A ³
	Polio 0	BCG	DPT3	Polio3	Measles	Full ²	None	
Andamans	97.3	99.3	84.9	64.1	85.4	57.9	0.7	74.8
Nicobars	87.3	96.8	86.0	85.7	85.5	78.7	1.9	80.3
Andaman & Nicobar Islands	91.9	98.0	85.6	75.7	85.5	69.3	1.2	77.6

Note: Table includes only last and last but one living child born since 1.1.1999/1.1.2001. ¹ Children age 12-23 months, ² BCG, DPT and three doses of Polio (excluding Polio 0) and measles vaccinations. ³ Children age 12-35 months.

The percentage of children who are fully vaccinated is very low in Andamans (58 percent) as compared to Nicobars (79 percent). Two percent of children in Nicobars district were not vaccinated at all. In Andamans district, less children have received 3 doses of Polio than any of the other vaccinations. The coverage of polio drops at the time of birth, however, is higher in Andamans (97 percent) than in Nicobars (87 percent).

District wise variations in the percentage of children who received at least one dose of Vitamin A are also shown in Table 5.8. The proportion of children in the age group 12-35 months who received at least one dose of Vitamin 'A' supplement is slightly lower in Andamans (75 percent) than in Nicobars (80 percent).

5.6 Child Morbidity and Treatment

This section discusses the awareness, prevalence and treatment of diarrhoea and acute respiratory infection (ARI). Mothers of surviving children born during three years preceding the survey were asked if their children suffered from cough and cold with difficulty in breathing or diarrhoea during the two weeks preceding the survey, and if so, the type of treatment that had been given. Accuracy of all these measures is affected by the reliability of the mother's recall of when the diseases occurred.

5.6.1 Awareness of Diarrhoea

Diarrhoea is a major killer disease of children under five years of age. Deaths from acute diarrhoea are mostly due to dehydration resulting from loss of water and electrolytes. An attempt was made to collect data on awareness of diarrhoea management and the practices followed during the episodes of diarrhoea. This has been presented in Table 5.9.

In Andaman & Nicobar Islands, 60 percent of the mothers with births during three years preceding the survey were aware of what to do when a child had diarrhoea, which was 7 percent points down from Round I, and 50 percent were aware of ORS, which was same as that of Round I. Around 39 percent of the women were aware of salt and sugar solution. Some of the women also reported that they would continue normal food (10 percent), continue breastfeeding (19 percent), and give plenty of fluids (25 percent), and 40 percent of women did not know what to give a child who had diarrhoea. As expected, knowledge of ORS is higher among urban women (62 percent) than among rural women (47 percent), and it is much higher among high school and above educated women (72 percent) as compared to non-literate women (28 percent). Christian women (42 percent) are less likely to know about ORS than Hindu (55 percent) and Muslim (54 percent) women. Women belonging to Schedule Tribes (34 percent) are less likely to know about ORS than women belonging to other caste groups (57-64 percent). Around 62 percent of women with children having a high standard of living know about ORS and it declines to 46 percent for women with a medium standard of living and 36 percent with a low standard of living. Knowledge of ORS is lower among younger women than among older women. Women from villages with availability of health facilities are more aware of diarrhoea management than women from other villages.

Table 5.9 AWARENESS OF DIARRHOEA

Percentage of women who are aware of diarrhoea management, type of practice followed if child gets diarrhoea, and percentage of women whose children suffered¹ from diarrhoea by selected background characteristics, Andaman & Nicobar Islands, 2002-04

Background characteristic	Knowledge of diarrhoea management	Type of practices to be followed if child gets diarrhoea					Do not know	Number of women
		Give ORS	Salt and sugar solution	Continue normal food	Continue breastfeeding	Give plenty of fluids		
Age								
15-24	51.5	41.8	35.1	9.8	16.9	17.7	48.5	211
25-34	64.4	54.0	39.8	10.3	19.7	27.8	35.7	439
35-44	(65.2)	(47.8)	(47.8)	(10.9)	(15.2)	(30.4)	(34.8)	46
Residence								
Rural	57.0	46.8	35.9	7.9	18.0	22.6	43.1	566
Urban	73.2	61.8	50.9	19.7	20.6	34.7	26.8	131
Mother's education								
Non-literate	41.7	28.0	29.2	2.5	12.0	10.2	58.3	125
0-9@ years	54.4	43.7	34.1	8.1	14.7	21.5	45.7	355
10 and above	79.8	71.8	51.7	17.9	28.4	38.9	20.2	217
Religion								
Hindu	64.7	54.6	44.0	12.0	17.6	26.7	35.4	352
Muslim	65.3	54.2	44.7	12.2	24.2	34.1	34.7	51
Christian	53.0	42.1	30.9	7.4	18.6	20.6	47.0	287
Caste/tribe#								
Scheduled caste								
Scheduled tribe	81.3	64.3	48.2	15.5	31.5	23.2	18.9	83
Other	47.1	34.1	30.1	3.5	16.3	19.7	52.9	208
	65.2	57.1	43.0	14.3	18.6	29.7	34.8	331
Standard of living index								
Low								
Medium	46.7	36.0	26.6	5.3	12.0	15.5	53.6	184
High	57.2	46.4	38.3	6.4	16.3	19.1	42.8	249
	72.1	62.3	47.6	17.1	25.2	37.0	27.9	263
Availability of health facility² in the village								
Yes								
No	61.6	50.7	38.3	9.1	19.6	23.5	38.5	442
	40.5	32.9	27.3	3.8	12.3	19.6	59.5	124
Total	60.0	49.7	38.7	10.2	18.5	24.9	40.0	697

Note: Table based on women with living children born since 01.01.1999 for phase - I /01.01.2001 for phase - II. ¹ Last two weeks prior to survey. Total includes 7 cases with other in religion and 21 cases with other backward class in caste/tribe were not shown separately. @ Literate mother with no years of schooling are included. # Total figure may not add to N due to do not know and missing cases. ² Includes sub-centre, primary health centre, Community health centre or referral hospital, government hospital, and government dispensary within the village. () based on less than 50 unweighted cases.

5.6.2 Treatment of Diarrhoea

During the last two weeks before the survey, around 8 percent of the women reported that their children suffered from diarrhoea (Table 5.10).

Table 5.10 TREATMENT OF DIARRHOEA					
Percentage of women whose children suffered from diarrhoea and who sought treatment and by source of treatment, according to place of residence and availability of health facility in the village, Andaman & Nicobar Islands, 2002-04					
Sought treatment/ source of treatment	Total	Residence		Availability of health facility ² in the village	
		Rural	Urban	Yes	No
Percentage of women whose child suffered ¹ from diarrhoea	8.4	8.4	8.6	9.0	6.0
Number of women	697	566	131	442	124
Percentage of women whose child suffered ¹ from diarrhoea treated with ORS	81.7	(78.3)	*	(77.5)	*
Percentage of women whose child suffered ¹ from diarrhoea sought treatment	93.2	(91.3)	*	(92.5)	*
Number of women	59	47	11	40	7
Source of treatment					
Government health facility					
Hospital/dispensary	27.2	(28.6)	*	(27.0)	*
UHC/UHP/UFWC	5.5	(0.0)	*	(0.0)	*
CHC/ Rural hospital	10.8	(23.8)	*	(27.0)	*
Primary health centre	50.8	(45.2)	*	(45.9)	*
Sub centre	8.5	(7.1)	*	(8.1)	*
Private health facility					
Private hospital clinic	4.2	(4.8)	*	(2.7)	*
ISM ³ facility	25.2	(26.2)	*	(27.0)	*
Home remedy	3.0	(2.4)	*	(2.7)	*
Percent distribution of women who seek treatment by					
Doctor	75.7	(76.2)	*	(73.0)	*
ANM/Nurse/LHV	24.3	(23.8)	*	(27.0)	*
Total percent	100.0	(100)	*	(100)	*
Number of women	55	44	10	38	6
Note: Table based on women with living children born since 01.01.1999 for phase - I /01.01.2001 for phase - II.					
¹ Last two weeks prior to survey. ² Includes sub-centre, primary health centre, Community health centre or referral hospital, government hospital, and government dispensary within the village. ³ Either government or private health facility of Indian System of Medicine. () Based on less than 50 unweighted cases. * Percentage not shown – based on very few cases.					

Women, whose children had diarrhoea, were further asked about treatment with ORS, any other medical treatment and source of treatment. As high as 82 percent of the women mentioned that they gave ORS therapy, and 93 percent of the women said that their children had been treated at health facility.

Among those mothers whose children suffered from diarrhoea during the last two weeks before the survey and who consulted or obtained advice, almost all the women visited government health facility and 4 percent visited private hospitals/clinics, and 25 percent of women treated their children through the Indian System of Medicine.

5.6.3 Awareness of Pneumonia

Another major killer disease among infants and children is Acute Respiratory Infections (ARI) including pneumonia. Early diagnosis and treatment with antibiotics can prevent a large proportion of ARI/pneumonia deaths. An attempt was made to understand the awareness levels of pneumonia, and the proportion of children who had suffered from pneumonia during the last two weeks before the survey and their health seeking behaviour. This is presented in Table 5.11. It was found that a very low proportion of women (16 percent) with births during three years preceding the survey in Andaman & Nicobar Islands were aware of danger signs of pneumonia, down from 23 percent in Round I. A relatively high proportion of women in urban areas (21 percent) were aware of the danger signs of pneumonia as compared to women from rural areas (15 percent). Knowledge of danger signs of pneumonia is relatively lower among younger women (8 percent), Christian women (14 percent), women from scheduled tribes (8 percent), non-literate women (5 percent), women living in low or medium standard of living households (each 10 percent) and women from villages having no health facility (7 percent).

Women, who were aware of the danger signs of pneumonia, were further asked about different types of signs of pneumonia. Most of the women mentioned about 'difficulty in breathing' (92 percent) followed by 'pain in chest and productive cough' (51 percent), 'rapid breathing' (38 percent), 'chest in drawing' (33 percent), 'not able to drink or take a feed' (32 percent), 'wheezing/whistling' (25 percent), 'excessive drowsy and difficulty in keeping awake' (13 percent) and 'condition get worse than before' (12 percent).

5.6.4 Treatment of Pneumonia

About 12 percent of women reported that their children had suffered from pneumonia during the last two weeks before the survey, this proportion being relatively higher in rural areas (13 percent) than in urban areas (8 percent) (Table 5.12). The incidence of pneumonia is higher among women from villages having health facilities (14 percent) than among those from villages having no health facility (9 percent).

Table 5.11 AWARENESS OF PNEUMONIA											
Percentage of women who are aware of danger signs of pneumonia by signs by selected background characteristics and availability of health facility in the village, Andaman & Nicobar Islands, 2002-04											
Background characteristic	Percentage of women aware of danger signs of pneumonia	Number of women	Danger signs of ARI								Number of women
			Difficulty in breathing	Chest in-drawing	Not able to drink or take a feeding	Excessive drowsy and difficulty in keeping awake	Pain in chest and productive cough	Conditions get worse than before	Wheezing/whistling	Rapid breathing	
Age											
15- 24	7.9	211	*	*	*	*	*	*	*	*	17
25-34	20.2	439	93.1	27.8	33.9	13.7	52.5	9.7	22.8	37.7	89
35-44	(17.4)	46	*	*	*	*	*	*	*	*	6
Residence											
Rural	15.0	566	92.7	30.8	27.6	11.7	54.6	10.9	26.4	42.1	85
Urban	20.7	131	(92.9)	(39.3)	(46.4)	(14.3)	(39.3)	(14.3)	(17.9)	(25.0)	27
Mother's education											
Non-literate	4.6	125	*	*	*	*	*	*	*	*	6
0-9@ years	12.9	355	(94.1)	(41.2)	(14.7)	(8.8)	(44.1)	(2.9)	(23.5)	(29.4)	46
10 and above	27.8	217	91.6	38.9	46.7	15.6	42.4	18.1	29.7	42.4	60
Religion											
Hindu	17.3	352	95.3	35.1	31.9	12.6	48.0	15.9	24.0	41.6	61
Muslim	17.5	51	*	*	*	*	*	*	*	*	9
Christian	14.3	287	(89.3)	(35.7)	(46.4)	(25.0)	(46.4)	(21.4)	(32.1)	(46.4)	41
Caste/tribe#											
Scheduled caste	25.2	83	*	*	*	*	*	*	*	*	21
Scheduled tribe	8.2	208	*	*	*	*	*	*	*	*	17
Other	20.6	331	95.5	27.4	31.4	14.1	50.4	9.9	22.4	34.6	68
Standard of living index											
Low	9.8	184	*	*	*	*	*	*	*	*	18
Medium	10.1	249	(95.8)	(37.5)	(29.2)	(12.5)	(45.8)	(16.7)	(33.3)	(29.2)	25
High	26.1	263	92.8	38.1	38.7	17.0	48.4	13.3	27.5	42.2	69
Availability of health facility² in the village											
Yes	17.3	442	92.8	29.9	26.8	10.6	57.9	12.1	28.6	46.0	76
No	6.9	124	*	*	*	*	*	*	*	*	9
Total	16.1	697	92.6	32.7	32.1	12.5	50.7	11.9	24.7	38.0	112

Note: Table based on women with living children born since 01.01.1999 for phase - I /01.01.2001 for phase - II. ¹ Last two weeks prior to survey. @ Literate mother with no years of schooling are included. # Total figure may not add to N due to do not know and missing cases. ² Includes sub-centre, primary health centre, Community health centre or referral hospital, government hospital, and government dispensary within the village. Total includes 7 cases with other in religion and 21 cases with other backward class in caste/tribe were not shown separately. () Based on less than 50 unweighted cases. * Percentage not shown – based on very few cases.

Table 5.12 also shows the percent of women whose children suffered from ARI symptoms in the last two weeks before the survey and sought advice/treatment and taken their children to a health facility or provider. Around 91 percent of women received some advice or treatment for their children who were ill with ARI.

Table 5.12 TREATMENT OF PNEUMONIA					
Percentage of women whose children suffered ¹ from cough and cold and who sought treatment and source of treatment, according to place of residence and availability of health facility in the village, Andaman & Nicobar Islands, 2002-04					
Sought treatment/ source of treatment	Total	Residence		Availability of health facility ² in the village	
		Rural	Urban	Yes	No
Percentage of women whose child suffered from cough, cold and difficulty in breathing	12.1	13.1	7.8	14.2	9.2
Number of women	697	566	131	442	124
Percentage of women sought treatment whose child suffered from cough and cold	91.2	91.6	*	92.0	*
Number of women	84	74	10	63	11
Source of treatment					
Government health facility					
Hospital/dispensary	11.9	7.1	*	2.1	*
UHC/UHP/UFWC	2.3	0.0	*	0.0	*
CHC/ Rural hospital	11.7	13.3	*	15.6	*
Primary health centre	61.0	69.1	*	76.5	*
Sub centre	9.9	11.2	*	5.6	*
Private health facility					
Private hospital clinic	4.0	1.7	*	2.1	*
ISM ³ facility	1.3	0.0	*	0.0	*
Home remedy	0.8	0.9	*	0.0	*
Percent distribution of women who seek treatment by					
Doctor	87.9	86.3	*	91.5	*
ANM/Nurse/LHV	11.3	12.8	*	8.5	*
Relative/friends	0.8	0.9	*	0.0	*
Total percent	100.0	100.0	*	100.0	*
Number of women	77	68	9	58	10
Note: Table based on women with living children born since 01.01.1999 for phase - I /01.01.2001 for phase - II. ¹ Last two weeks prior to survey. ² Includes sub-centre, primary health centre, Community health centre or referral hospital, government hospital, and government dispensary within the village. ³ Either government or private health facility of Indian System of Medicine. * Percentage not shown – based on very few cases.					

Among the women who got advice for children ill with ARI, almost all visited government health facility and only 4 percent went to private hospital/clinic.

5.6.5 Awareness of Diarrhoea, ORS and Pneumonia and Incidence of Diarrhoea and Pneumonia by Districts

Table 5.13 presents the knowledge of diarrhoea management, knowledge of ORS, and incidence of diarrhoea by district. Knowledge of diarrhoea management and knowledge about ORS is relatively higher in Andamans than in Nicobars, in Andaman & Nicobar Islands. Knowledge of ORS is lower in Nicobars (43 percent) than in Andamans (56 percent). The incidence of diarrhoea is 8 percent in the union territory as a whole and it is lower in Nicobars (6 percent) than in Andamans (11 percent). Table 5.13 also shows differentials in the awareness of danger signs of pneumonia and incidence of pneumonia by district. In comparison to awareness about diarrhoea management, the awareness of danger signs of pneumonia is quite low in both the districts. It is lower in Nicobars (10 percent) than in Andamans (22 percent). Incidence of ARI symptoms is higher in Andamans (17 percent) than in Nicobars (8 percent).

Table 5.13 KNOWLEDGE OF DIARRHOEA MANAGEMENT AND PNEUMONIA BY DISTRICT					
Percentage of women by awareness of diarrhoea management, ORS, danger signs of pneumonia and whose children suffered from diarrhoea and pneumonia during last two weeks prior to survey by district, Andaman & Nicobar Islands, 2002-04					
District	Percentage of women aware of		Percentage of women whose child suffered ¹ from diarrhoea	Percentage of women aware of danger signs of pneumonia	Percentage of women whose child suffered ¹ from pneumonia
	Diarrhoea Management	ORS			
Andamans	66.8	56.3	10.9	21.7	16.6
Nicobars	53.0	43.3	6.0	10.1	7.7
Andaman & Nicobar Islands	60.0	49.7	8.4	16.1	12.1

Note: Table based on women with last and last but one living children born since 01.01.1999 /01.01.2001. ¹ Last two weeks prior to survey.

CHAPTER VI

FAMILY PLANNING

The Reproductive and Child Health Programme has been implemented with a new philosophy and direction to meet the health care needs of women and children. It envisages the provision of contraceptive services to couples to control their fertility and have sexual relations free from the fear of pregnancy. Provision of free contraceptive services to all the needy couples is one of the components of the RCH programme. In DLHS-RCH, a separate section on family planning was canvassed to all the eligible women to assess the knowledge and practice of various family planning methods. The information on source of currently adopted contraceptive method, source of supply of the method and health problems related to contraceptive use was collected from current users. The current non-users were asked about the past status of contraceptive use, reasons for not using contraceptives currently and future intention to adopt a family planning method.

An attempt was made to understand why male methods of family planning especially that of vasectomy was not in common use. The husbands of sampled eligible women were asked about the contraceptive methods they would recommend to a couple who was not desirous of any additional children. They were also asked about the reasons for not preferring male methods and their knowledge about the no-scalpel vasectomy. This chapter presents the results of data on contraceptive practices collected from both the sampled women and their husbands.

6.1 Knowledge of Family Planning Methods

Lack of knowledge of various contraceptive choices can be a major barrier to promotion and use of contraceptives among couples. In DLHS-RCH, information on knowledge of contraceptives was obtained by asking a question, "Which are the family planning methods you know?" to each sampled eligible woman. A question on the knowledge of no-scalpel vasectomy (NSV) was also asked to the husbands of eligible women. If the respondent did not recognise the name of the family planning method, she was given a brief description on how the particular method was to be used. The DLHS-RCH assesses the knowledge of female sterilisation, male sterilisation including NSV, IUD, Pills, condom and traditional methods along similar lines.

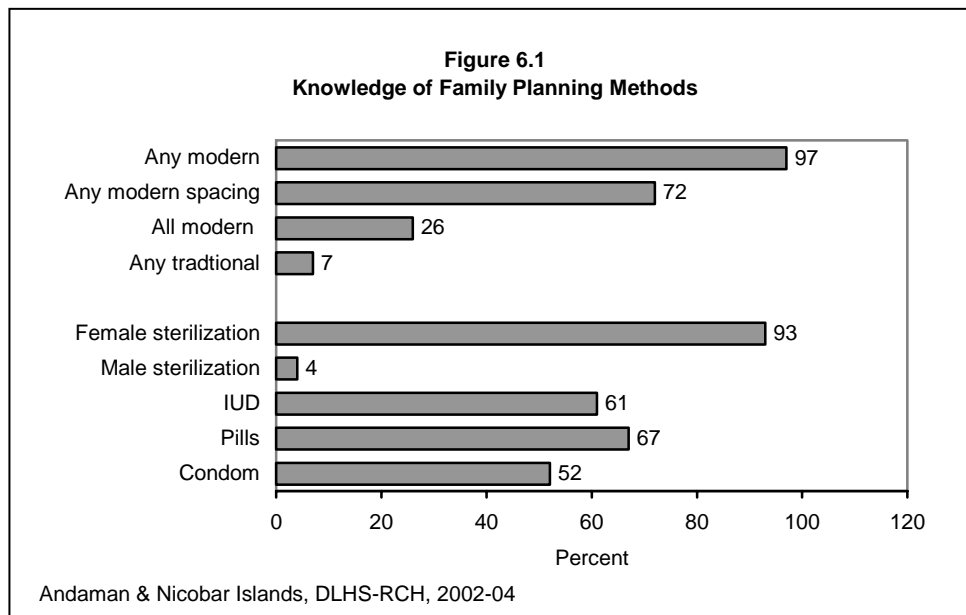
The extent of knowledge of contraceptive methods among currently married women for specific methods according to residence and availability of health facilities in the village is shown in Table 6.1 and Figure 6.1. Knowledge of any method including any modern contraceptive method is almost universal in the union territory of Andaman & Nicobar Islands and do not vary by residence. The knowledge of modern spacing methods among currently married women is around 72 percent, and comparatively higher among the women with an urban residence. Around 24 percent of women from rural areas are aware about all modern methods compared to 33 percent of their urban counterparts.

Table 6.1 KNOWLEDGE OF CONTRACEPTIVE METHODS					
Percentage of currently married women age 15-44 years who know any contraceptive method by specific method according to place of residence and availability of health facility in the village, Andaman & Nicobar Islands, 2002-04					
Contraceptive methods	Total	Residence		Availability of health facility in the village ³	
		Rural	Urban	No	Yes
Any method	97.8	97.5	98.8	98.9	97.1
Any modern method	97.4	97.0	98.8	98.7	96.5
Any modern spacing method ¹	71.9	70.1	80.7	65.8	71.3
All modern methods ²	25.6	24.1	32.9	21.0	25.0
Female sterilization	92.6	93.3	89.8	96.1	92.4
Tubectomy	48.7	46.3	59.7	53.2	44.2
Laparoscopy	16.7	15.1	24.4	14.9	15.1
Male sterilization					
Vasectomy	39.9	37.4	51.5	32.0	39.1
No-scalpel vasectomy	23.8	22.8	28.0	19.1	24.0
vasectomy	6.9	6.4	9.2	5.4	6.6
IUD/Loop	60.6	58.3	71.5	56.2	58.9
Pills					
Daily	67.0	65.3	75.1	60.0	66.9
Weekly	17.9	18.9	13.3	16.6	19.6
Condom/Nirodh	8.4	7.6	12.1	8.1	7.5
Sponge (today)	51.9	50.6	58.2	44.0	52.6
Injectables	2.4	2.4	2.3	1.4	2.7
Norplant	2.8	2.4	4.6	1.3	2.8
Contraceptive herbs	0.9	1.0	0.8	0.4	1.2
Any traditional method	1.6	1.5	1.9	1.7	1.5
Any other Indian system of medicinal contraceptives	7.0	7.0	6.9	5.4	7.5
	0.5	0.6	0.4	0.2	0.7
Number of women	1,782	1,467	315	339	1,128

Note:¹ Include IUD, pills and condom. ² Include Female sterilization, Male sterilization, IUD, pills and condom. ³ Includes sub-centre, primary health centre, community health centre or referral hospital, government hospital, and government dispensary within the village.

Female sterilisation is the most widely known method of all contraceptive methods in Andaman & Nicobar Islands followed by Pills and IUD/Loop. Overall, most of the currently married women (93 percent) are aware of female sterilization and 40 percent knew about male sterilization. There is not much rural - urban difference in knowledge of female sterilization, but it is higher in urban areas in the case of male sterilization. The best-known spacing methods are Pills (67 percent), IUD/Loop (61 percent) and condoms (52 percent). There is a large differential in knowledge of spacing methods by residence. The three modern spacing methods, Pill, IUD/Loop and condom are known by 65, 58 and 51 percent of rural women respectively, while the corresponding figures in urban areas are 75, 72 and 58 percent of eligible women respondents. The knowledge of these spacing methods is moderate as compared to knowledge of sterilization.

In Andaman & Nicobar Islands, only 7 percent of the women are aware of any traditional method and less than one percent are aware of any other contraceptives of the Indian System of Medicine. It is also observed that women from villages with a health facility are slightly more aware about modern spacing methods.



6.1.1 Knowledge of Family Planning Methods by Districts

Table 6.2 shows the knowledge of contraceptive methods by district in Andaman & Nicobar Islands. In both the districts, more than 97 percent of women know about contraceptives including modern methods. A large differential is noticed in the knowledge of any modern spacing methods or all modern methods by districts. The awareness is higher in Andamans than in Nicobars district. There is not much variation in the knowledge of female sterilization, which is slightly higher in Nicobars (94 percent) than in Andamans (91 percent). Knowledge about Pill, IUD/Loop and condom is 77, 72 and 59 percent respectively in Andamans district, whereas they are 57, 48 and 44 percent in Nicobars district. Knowledge of any traditional method is also relatively higher in Andamans (10 percent) than in Nicobars (4 percent).

Table 6.2 KNOWLEDGE OF CONTRACEPTIVE METHODS BY DISTRICT

Percentage of currently married women age 15-44 years who know any contraceptive method by specific method and district, Andaman & Nicobar Islands, 2002-04

Districts	Any method	Any modern ¹ method	Any modern spacing ² method	All modern ³ methods	Male sterilization	Female sterilization	IUD	Pill	Condom /Nirodh	Any traditional method
Andamans	98.3	98.0	82.1	33.9	53.2	91.3	72.2	76.8	59.4	9.9
Nicobars	97.3	96.8	61.4	17.5	26.8	94.4	48.4	56.9	44.2	4.1
Andaman & Nicobar Islands	97.8	97.4	71.9	25.6	39.9	92.6	60.6	67.0	51.9	7.0

Note: ¹ Includes Female sterilization, Male sterilization, IUD, Pills and Condom. ² Includes IUD, Pills and Condom. ³ Includes Female sterilization & Male sterilization & IUD & Pills and Condom.

6.1.2 Knowledge of No-Scalpel Vasectomy (NSV)

Knowledge of no-scalpel vasectomy among the husbands of currently married women in the union territory of Andaman & Nicobar Islands is shown in Table 6.3. Only about one-tenth of the husbands know about the no-scalpel vasectomy, more or less similar in rural and urban areas. For women residing in villages with a health facility, about 12 percent of their husbands are aware of No-scalpel vasectomy and it is 9 percent for those living in villages without health facilities. Among the husbands who know about NSV, 77 percent reported that NSV is simpler than conventional vasectomy, 69 percent feel that NSV does not lead to any complication and 67 percent reported that NSV does not affect a man's sexual performance.

Table 6.3 KNOWLEDGE OF NO-SCALPEL VASECTOMY (NSV)

Husbands knowledge of NSV by residence and availability of health facility in the village, Andaman & Nicobar Islands, 2002-04

Knowledge of NSV	Total	Residence		Availability of health facility in the village ¹	
		Rural	Urban	No	Yes
Percentage of husband who had knowledge about NSV	10.3	10.8	9.0	9.1	11.5
Number of husbands	1,140	817	323	238	580
Who know that NSV is simpler than conventional vasectomy	77.2	76.0	(80.0)	*	76.4
Who feel that NSV does not lead to any complication	69.1	75.4	(53.3)	*	77.1
Who feel that NSV does not affect man's sexual performance	66.5	68.5	(60.0)	*	70.9
Number of husbands	117	88	29	22	67

Note: ¹ Includes sub-centre, primary health centre, community health centre or referral hospital, government hospital, and government dispensary within the village. () Based on less than 50 unweighted cases. * Percentage not shown; based on few cases.

6.1.3 Knowledge of No-Scalpel Vasectomy (NSV) by Districts

No-scalpel vasectomy awareness by districts in Andaman & Nicobar Islands is provided in Table 6.4. A slightly lower proportion of the husbands in Andamans district (10 percent) know about the no-scalpel vasectomy as compared to those in Nicobars district (13 percent). That NSV does not lead to any complications was reported by as high as 84 percent of the husbands in Andamans district as against 40 percent in Nicobars district. The proportions of husbands who reported that the NSV does not lead to complications (72 percent) and that the NSV does not affect a man's sexual performance (70 percent) were also higher in Andamans district, the corresponding figures in Nicobars being 53 and 48 percent.

Districts	Knowledge about NSV	NSV is simpler than conventional method	Who reported NSV does not lead to any complication	Who reported NSV does not affect man's sexual performance
Andamans	9.9	83.7	71.9	69.8
Nicobars	13.2	40.0	52.9	47.6
Andaman & Nicobar Islands	10.3	77.2	69.1	66.5

6.2 Current use of Family Planning Methods

Table 6.5 and Figure 6.2 provide the information on current use of family planning methods for currently married women in Andaman & Nicobar Islands. At the time of DLHS-RCH, 58 percent of currently married women were using some method of contraception, 4 percentage points drop from Round I. Current contraceptive use is higher in urban areas than in rural areas. Use of modern methods is reported by 57 percent of the women, the breakdown of which is 46 percent for permanent methods and 11 percent for spacing methods. Among the users of sterilization methods most prefer female sterilization (46 percent), which invalidates the use of male sterilization (1 percent).

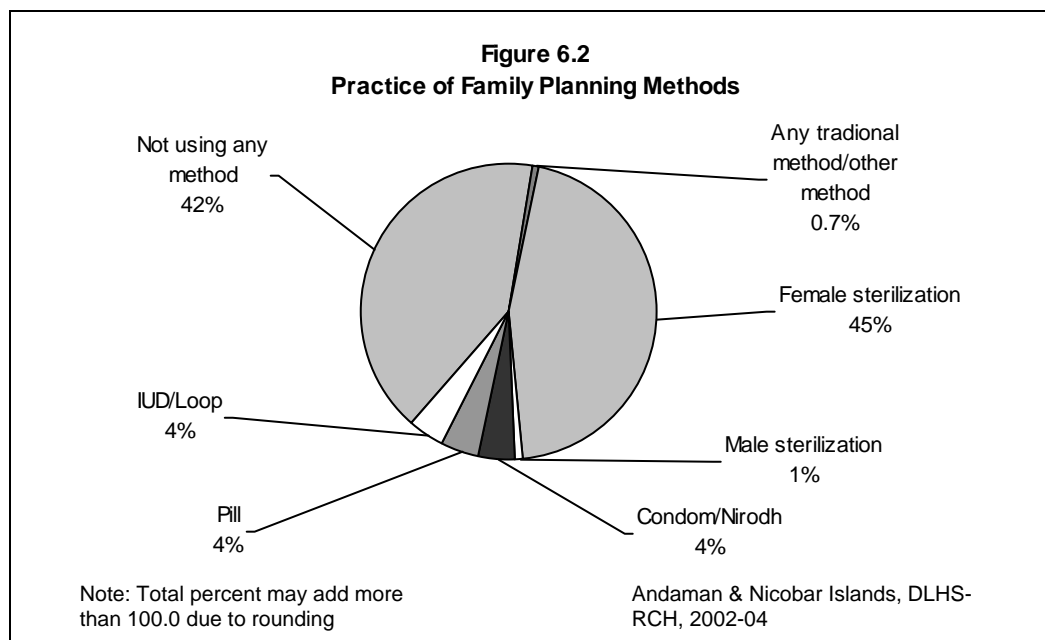
Table 6.5 CONTRACEPTIVE PREVALENCE RATE

Percentage of currently married women age 15-44 years currently using any contraceptive method by selected background characteristics, Andaman & Nicobar Islands, 2002-04

Method	Any method	Any modern ¹ method	Any modern spacing method ²	Any sterilization	Male sterilization	Female sterilization	IUD/ Loop	Pill	Condom / Nirodh	Any traditional method ³	Rhythm/ periodic abstinence	Withdrawal	Number of women
Residence													
Rural	57.2	56.5	9.6	46.8	1.0	45.8	2.8	3.7	3.2	0.6	0.5	0.0	1,467
Urban	62.2	61.0	19.3	41.2	1.6	39.6	8.5	2.6	8.2	1.2	0.6	0.6	315
Education													
Non-literate	57.9	57.9	2.4	55.1	0.0	55.1	0.8	0.6	1.0	0.0	0.0	0.0	392
0-9@ years	58.7	58.2	10.1	48.1	2.1	46.0	3.3	3.2	3.6	0.4	0.2	0.1	866
10 years & above	57.1	55.4	19.9	35.1	0.3	34.8	6.7	6.0	7.2	1.7	1.3	0.2	524
Religion													
Hindu	61.5	60.8	13.7	46.9	1.9	45.0	5.0	4.0	4.7	0.7	0.5	0.2	915
Muslim	62.5	60.5	21.2	39.3	1.5	37.8	8.3	2.8	10.1	2.0	2.0	0.0	138
Christian	52.3	51.8	6.2	45.4	0.1	45.3	1.0	2.9	2.2	0.5	0.2	0.0	704
Other	(62.5)	(62.5)	(20.8)	(41.7)	(0.0)	(41.7)	(8.3)	(4.2)	(8.3)	(0.0)	(0.0)	(0.0)	26
Caste/tribe#													
Scheduled caste	44.6	42.8	13.4	29.4	0.5	28.9	2.8	7.1	3.5	1.8	1.8	0.0	187
Scheduled tribe	57.1	56.7	3.6	52.8	0.1	52.6	0.7	1.8	1.1	0.4	0.0	0.0	517
Other backward class	(78.0)	(76.0)	(26.0)	(50.0)	(0.0)	(50.0)	(16.0)	(4.0)	(6.0)	(2.0)	(2.0)	(0.0)	38
Other	60.5	59.7	14.7	44.9	1.7	43.2	0	3.8	5.8	0.8	0.6	0.2	925
Standard of living index													
Low	49.6	49.1	6.0	42.7	0.9	41.8		2.6	1.8	0.5	0.3	0.0	429
Medium	58.2	57.6	9.8	47.8	0.3	47.5	1.5	4.2	3.6	0.6	0.6	0.0	629
High	62.9	62.0	15.8	45.9	2.0	43.9	2.0	3.4	5.9	0.9	0.5	0.3	724
Availability of health facility in the village⁴													
No	63.1	63.1	7.7	55.5	1.1	54.4		3.5	1.3	0.0	0.0	0.0	339
Yes	55.4	54.6	10.2	44.2	1.0	43.2	2.8	3.7	3.8	0.8	0.6	0.0	1,128
Total	58.1	57.3	11.3	45.8	1.1	44.7	2.7	3.5	4.1	0.7	0.5	0.1	1,782
							3.8						

Note:¹Include Female sterilization, Male sterilization, IUD, Pills and Condom. ² Include IUD, Pills and Condom. ³ Include Rhythm/Periodic abstinence, Withdrawal and Other traditional method. ⁴ Literate women with no years of schooling are also included. #Total figure may not add to N due to don't know and missing cases. ⁴ Includes sub-centre, primary health centre, community health centre or referral hospital, government hospital, and government dispensary within the village. () based on less than 50 unweighted cases.

The use of traditional methods is reported by 0.7 percent of the women of which 0.5 percent are using the rhythm or periodic abstinence practice.



Current use of contraception is higher among Muslim (63 percent) and Hindu (62 percent) women than among Christian women (52 percent). Current use of contraception is high among women of 'other castes' category (61 percent) than among scheduled caste women (45 percent) and women belonging to scheduled tribes (57 percent). But, the current use is marginally lower among the women with more than 10 years of schooling (57 percent) than among women who are non-literate (58 percent) and also who have less than 10 years of schooling (59 percent). However, current contraceptive use varies positively with respect to the standard of living of the women, increasing the prevalence rate from 50 percent to 63 percent for women from the lowest to the highest standard of living households. The availability of the health facility in the village did not help in motivating eligible women to use contraceptives. Around 55 percent of the women living in villages with a health facility are currently under contraception, while this is 63 percent for the women from the villages with no health facility.

6.2.1 Current Use of Family Planning Methods by Districts

Table 6.6 presents a picture of current contraceptive use in the districts of Andaman & Nicobar Islands. The contraceptive use is a couple concept as family planning methods can be used either by women or by their husbands. The current use of contraception is 60 percent of eligible women in Andamans district, while it is 57 percent in Nicobars district. The union territory figure of current spacing methods use is 11 percent and it is 15 percent in Andamans, while it is 8 percent in Nicobars. The variation in contraceptive prevalence at district level is due to the variation both in the use of permanent methods as well as in the use of modern spacing methods.

Table 6.6 CONTRACEPTIVE PREVALENCE RATES BY DISTRICTS									
Percentage of currently married women age 15-44 years currently using any contraceptive method by district, Andaman & Nicobar Islands, 2002-04									
Districts	Any method	Any modern ¹ method	Any modern spacing ² method	Male sterilization	Female sterilization	IUD	Pill	Condom / Nirodh	Any traditional ³ method
Andamans	60.1	59.3	14.7	2.0	42.4	5.0	3.7	6.0	0.8
Nicobars	56.8	56.1	7.7	0.1	48.2	2.5	3.0	2.2	0.7
Andaman & Nicobar Islands	58.1	57.3	11.3	1.1	44.7	3.8	3.5	4.1	0.7

Note: ¹ Include Female sterilization, Male sterilization, IUD, Pills and Condom. ² Include IUD, Pills and Condom. ³ Include Rhythm/Periodic abstinence, Withdrawal and Other traditional method

6.2.2 Current Use and Ever Use of Family Planning Methods by Women

Table 6.7 provides information on current contraceptive use and ever use of contraception by age and number of surviving children and living sons and daughters. The current use of any method of contraception is found among one-tenth of currently married women in the 15-19 years age group and this attains a peak of 75 percent in the age group, 35-39 and 40-44 years. A similar age pattern of contraceptive use is also observed in case of modern methods.

It is crucial to understand the association between the number of living children and contraceptive use. The contraceptive use is high among the women who have two surviving children and it is much higher among women with two or more surviving children in Andaman & Nicobar Islands. The use of any method of contraception is 75 percent for the women who have two or more sons and is slightly higher than for the women who have two or more daughters (72 percent). The similar proportions can be observed in the case of use of any modern methods. It is also to be noted here that the proportions of couples using any contraceptive method and any modern method are almost the same in Andaman & Nicobar Islands.

Table 6.7 USE OF CONTRACEPTION BY WOMEN

Percentage of currently married women in 15-44 years by current use and ever use of contraception according to selected demographic characteristics, Andaman & Nicobar Islands, 2002-04

Demographic Characteristic	Percentage of women/husbands using				Percentage of women/husbands by contraceptive status		Number of women
	Any modern method ¹	Any traditional method ²	Any method	Not using any method	Ever used	Never used	
Age-group	(10.3)	(0.0)	(10.3)	(89.7)	(10.3)	(89.7)	48
15-19	31.0	0.4	31.4	68.6	37.7	62.3	300
20-24	53.9	1.3	55.2	44.8	59.8	40.2	531
25-29	64.6	1.1	65.7	34.3	71.1	28.9	383
30-34	74.9	0.0	74.9	25.1	78.2	21.8	299
35-39	74.7	0.0	74.7	25.3	75.5	24.5	220
40-44							
Surviving children							
0	4.9	0.0	4.9	95.1	7.5	92.5	168
1	30.6	1.1	31.8	68.2	39.3	60.7	430
2	75.0	1.0	76.0	24.0	80.3	19.7	673
3 or more	73.8	0.2	74.0	26.0	75.9	24.1	511
Surviving sons							
0	33.3	1.0	34.3	65.7	39.9	60.1	525
1	62.7	0.9	63.6	36.4	68.8	31.2	768
2 or more	74.6	0.2	74.8	25.2	76.1	23.9	489
Surviving daughters							
0	41.5	0.3	41.8	58.2	46.1	53.9	656
1	63.5	1.1	64.7	35.3	69.1	30.9	694
2 or more	71.4	0.7	72.2	27.8	76.1	23.9	432
All women	57.3	0.7	58.1	41.9	62.3	37.7	1,782

Note: ¹ Include Female sterilization, Male sterilization, IUD, Pills and Condom. ² Include Rhythm/Periodic abstinence, Withdrawal and Other traditional method. () based on less than 50 unweighted cases.

6.2.3 Current Use and Ever Use of Family Planning Methods as Reported by Husbands

Information pertaining to current use of family planning methods among the husbands of currently married women in Andaman & Nicobar Islands by age and number of surviving children, sons and daughters is given in Table 6.8. The current use of any method of contraception is found among one-fifth of the husbands (aged below 25 years) of currently married women and it gradually picks up with the age of husband, to a peak of 76 percent for the husbands age 45 years or above. Similar age pattern of contraceptive use is also observed in the case of modern methods.

Table 6.8 USE OF CONTRACEPTION BY MEN					
Percentage of husbands of currently married women by current use and ever use of contraception by selected demographic variables, Andaman & Nicobar Islands, 2002-04.					
Demographic <i>Characteristics</i>	Percentage of husbands/women using				Number of men
	Any modern method ¹	Any traditional method ²	Any method	Not using any method	
Age-group					
<25	(19.4)	(0.0)	(19.4)	(80.6)	31
25-34	44.1	1.4	45.5	54.5	426
35-44	69.5	1.9	71.4	28.6	466
45+	76.2	0.1	76.4	23.6	216
Surviving children					
0	4.9	0.0	4.9	95.1	101
1	33.9	3.6	37.5	62.5	273
2	75.4	1.0	76.4	23.6	422
3 or more	78.5	0.2	78.6	21.4	344
Surviving sons					
0	37.4	1.7	39.2	60.8	309
1	64.4	1.8	66.2	33.8	497
2 or more	74.7	0.2	74.9	25.1	334
Surviving daughters					
0	43.4	1.5	44.9	55.1	450
1	68.3	1.5	69.8	30.2	399
2 or more	74.8	0.7	75.5	24.5	291
All men	60.1	1.3	61.4	38.6	1,140

Note: ¹ Include Female sterilization, Male sterilization, IUD, Pills and Condom. ² Include Rhythm/Periodic abstinence, Withdrawal and Other traditional method. () based on less than 50 unweighted cases.

6.3 Reasons for Not Using Male Methods

The DLHS-RCH asked husbands of currently married women about the contraceptive methods that he or his wife was using currently. The husbands who were not using male methods were further asked about the reasons for the same. Table 6.9 provides information about reasons for not using male contraceptive methods in Andaman & Nicobar Islands. Among all the husbands interviewed, 87 percent reported about use of female methods. Reporting use of female methods is more or less the same in rural (87 percent) and urban (86 percent) areas. The main reasons cited for not preferring the male methods are 'greater popularity of female methods' (55 percent) and 'fear of weakness' (34 percent). 'Fear of operation' (9 percent) and 'fear of impotency' (8 percent) were also cited as reasons for not accepting male methods by few husbands of the currently married women. The expression for fear of weakness is higher in urban areas (43 percent) than in rural areas (30 percent). Popularity of female methods as a reason for not using male methods of contraception is more or less the same in urban (54 percent) and rural (56 percent) areas.

Table 6.9 REASONS FOR NOT USING MALE METHODS			
Percentage of husbands reporting use for family planning methods and reasons for not accepting male methods according to residence, Andaman & Nicobar Islands, 2002-04			
Female method users and reason for not accepting male methods	Total	Residence	
		Rural	Urban
Percentage of husband who have reported female methods	86.7	87.1	85.5
Number of men	700	503	198
Reasons for not accepting male methods*			
Fear of impotency	8.3	5.8	14.7
Lack of sexual pleasure	1.8	1.7	2.2
Fear of method failure	1.8	1.7	2.1
Fear of operation	9.4	11.0	5.1
Fear of weakness	33.6	30.1	42.7
Female methods are more popular	55.2	55.6	54.1
Other	7.4	8.1	5.8
Number of men	607	438	169
Note: * Percentages may add to more than 100.0 because multiple responses could be recorded.			

6.4 Sources of Contraceptive Methods

To assess the various sources of contraceptive methods, DLHS-RCH collected information on sources of obtaining methods. Table 6.10 and Figure 6.3 show the percent distribution of current users of modern contraceptives by source of contraceptives. Family planning methods and services in Andaman & Nicobar Islands are provided primarily through a network of government hospitals. The services are also provided by a few private hospitals and clinics. Modern spacing methods like IUD, Pill and condom are also mainly available through the government sector. Government/municipal hospitals are the main sources for female sterilization (54 percent) followed by community health centres or primary health centres (43 percent). For IUD/Loop as well, the aforesaid are the main sources. However, for Pills the main sources are the community health centres or primary health centres (37 percent) followed by sub-centres (32 percent). It is also found that the community health centres or primary health centres are the main sources for Condom/Nirodh (28 percent) followed by chemist (20 percent) and sub-centres (18 percent).

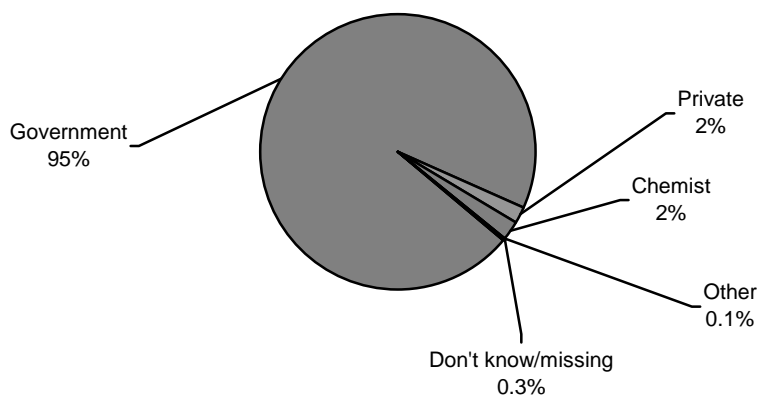
Table 6.10 SOURCE OF MODERN CONTRACEPTIVE METHODS

Percent distribution of current users of modern contraceptive methods by method and source of supply, Andaman & Nicobar Islands, 2002-04

Source	Contraceptive method					All modern methods ¹
	Female sterilization	Male sterilization	IUD/ Loop	Pills	Condom / Nirodh	
Government medical centre	98.3	*	96.0	84.3	67.6	95.1
Government/Municipal hospital	53.7	*	47.3	11.2	17.7	47.8
CHC/PHC	43.1	*	36.7	37.1	27.9	41.6
Sub-centre	0.3	*	10.6	31.9	17.6	4.1
Government doctor	0.1	*	0.0	4.1	0.6	0.4
Government nurse/ ANM	0.0	*	0.0	0.0	1.3	0.1
Family planning/RCH camp	1.0	*	1.4	0.0	0.0	0.9
Out reach/MCP clinic in village	0.0	*	0.0	0.0	1.4	0.1
Mobile clinic	0.1	*	0.0	0.0	1.2	0.2
Private medical centre	1.6	*	2.4	3.8	8.4	2.3
Private hospital	1.4	*	2.4	3.2	4.1	1.8
Private doctor	0.1	*	0.0	0.6	3.9	0.4
Private nurse	0.1	*	0.0	0.0	0.4	0.1
Chemist	NA	NA	NA	11.9	20.4	2.2
Other	0.1	*	0.0	0.0	0.9	0.1
Missing	0.0	*	1.6	0.0	2.6	0.3
Total percent	100.0	*	100.0	100.0	100.0	100.0
Number of users	797	20	67	62	73	1,018

Note: ¹Includes female sterilization, male sterilization, IUD, Pills or condom. CHC: Community health centre, PHC: Primary health centre. NA: Not applicable.

Figure 6.3
Sources of Family Planning Methods Among Current Users of Modern Contraceptive Methods



Note: Total percent may add more than 100.0 due to rounding

Andaman & Nicobar Islands, DLHS-RCH, 2002-04

6.5 Problems with Current Use of Contraceptive Methods

Women who were using a modern contraceptive method were asked if they had experienced any problems related with the current methods they are using. Table 6.11 shows the percentage of current contraceptive users who reported specific health problems. The analysis of the method specific problems reveals that 4 percent of the sterilized women have problems with the contraceptive method in use. The most common problems experienced by sterilized women are ‘body ache or backache’, ‘weakness or inability to work’, ‘dizziness’, ‘white discharge’, ‘cramps’ and ‘weight gain’. With regard to the modern spacing methods, 4 percent and 5 percent of women had problems in using IUD/loop and Pills respectively.

Table 6.11 HEALTH PROBLEMS WITH CURRENT USE OF CONTRACEPTION			
Percentage of women informed about side effects, had side effects with the method by use of method, Andaman & Nicobar Islands, 2002-04			
Health problems/side effect	Type of method		
	Female sterilizations	IUD/loop	Pill
Women who were informed about all the available methods	47.3	NA	NA
Women who were informed about the side effects before adoption of the method	46.6	76.9	71.1
Women who had side effect/health problem due to use of contraceptive method	3.9	4.3	5.0
Number of current users	797	67	62
Type of health problems/side effects¹			
Weakness/inability to work	(42.3)	*	*
Body ache/ backache	(57.7)	*	*
Cramps	(11.5)	*	*
Weight gain	(11.5)	*	*
Dizziness	(23.1)	*	*
Nausea/vomiting	(3.8)	*	*
Breast tenderness	(3.8)	*	*
Irregular periods	(7.7)	*	*
Excessive bleeding	(7.7)	*	*
White discharge	(11.5)	*	*
Number of users with side effects	31	3	3
Note: ¹ Percentages may add to more than 100.0 because multiple problems could be recorded. () based on less than 50 unweighted cases. * Percentage not shown based on very few cases. NA: Not applicable.			

6.6 Treatment for Health Problems with Current Use of Contraception

The study of respondents who sought treatment for contraceptive related health problems (Table 6.12) reveals that more-than two-thirds of the sterilized women sought treatment. Regarding the satisfaction about the methods, 91 percent of the sterilized women reported satisfaction with sterilization. In the case of spacing methods, 98 percent of women using IUD/loop and 95 percent of women using Pills were satisfied with the respective methods.

Table 6.12 FOLLOW-UP VISIT AND SOUGHT TREATMENT FOR HEALTH PROBLEMS WITH CURRENT USE OF CONTRACEPTION			
Percentage of women who had follow-up visit, satisfied with current method, and sought treatment for side effect with the method by use of method, Andaman & Nicobar Islands, 2002-04			
Health problems/side effect	Type of method		
	Female sterilizations	IUD/loop	Pill
Women who had follow up visit by health worker after adoption of method	17.9	22.7	21.9
Women who are satisfied with method of current use	95.1	98.0	94.9
Number of current users	797	67	62
Women who sought treatment for the health problem	(69.2)	*	*
Number of women with side effects	31	3	3

Note: ¹ Either government or Private. () based on less than 50 unweighted cases. * Percentage not shown – based on very few cases.

6.7 Advice to Non-Users to Use Contraception

Information about non-users who were advised by the ANM/health worker to adopt contraceptives according to residence and availability of health facility in the villages is presented in Table 6.13. In DLHS-RCH currently married women who were not using any method of contraception, were asked about advice given by ANM/health worker for adoption of any contraceptive method. It is evident that about 44 percent of the women were advised by ANM/health worker to adopt any family planning method in Andaman & Nicobar Islands. More or less the same proportion of urban and rural women were advised by ANM/health worker to adopt any method.

Table 6.13 ADVICE ON CONTRACEPTIVE USE					
Percentage of current non-users* who were advised by the ANM/health worker to use contraception by suggested method according to place of residence and availability of health facility in the village, Andaman & Nicobar Islands, 2002-04					
Advise/future intension to use	Total	Residence		Availability of health facility in the village ¹	
		Rural	Urban	No	Yes
Percentage of current non-users advised by ANM/health worker to use of contraceptive method	43.9	44.1	43.1	39.7	45.2
Number of non-users	739	619	119	123	496
Percent distribution of women who were advised by method					
Female sterilization	48.7	49.5	44.7	(48.0)	51.2
Male sterilization	1.9	2.3	0.0	(0.0)	2.8
IUD/loop	32.9	30.4	46.5	(32.0)	28.6
Pill	8.2	8.6	6.5	(6.0)	9.2
Condom/Nirodh	6.1	6.8	2.3	(8.0)	7.1
Other	2.1	2.5	0.0	(6.0)	1.1
Total percent	100.0	100.0	100.0	(100.0)	100.0
Number of non-users	324	273	51	49	224
Note: * Exclude women in menopause or those who have undergone hysterectomy. ¹ Includes sub-centre, primary health centre, community health centre or referral hospital, government hospital, and government dispensary within the village. () based on less than 50 unweighted cases.					

The recommended contraceptive methods by ANM/health worker is mainly the female sterilization (49 percent) followed by IUD/Loop (33 percent). Only 2 percent were advised to accept male sterilization and 8 and 6 percent respectively were advised to adopt Pills and Condom/Nirodh as spacing methods. Similar pattern of advice also emerges irrespective of residence and availability of health facility in the village.

6.7.1 Future Intentions to use Contraception

Currently married women who were not using any contraceptive method at the time of survey were asked about their intentions to use a method in the future. Those women who intended to use contraceptives in the future were further asked about preferred methods. This type of information aids the managers and programmers to identify the potential groups of future users and to provide the type of contraceptives that are likely to be in demand.

Future intention to use contraception by current non-users is shown in Table 6.14. Among the non-users, around 42 percent of women have expressed their intention to use any method of contraception in the future. The intention to use any method of contraception is slightly more in urban areas (44 percent) than in rural areas (41 percent).

Among the women who intended to use contraception in the future, around 73 percent preferred female sterilization, whereas less than one of the women only preferred male sterilization. A sizeable proportion of the women (16 percent) preferred the modern spacing method IUD/copper-T/loop, while 7 percent and 2 percent of the women respectively the other two modern spacing methods viz. Oral Pills and Condom/Nirodh.

Table 6.14 FUTURE INTENTION TO USE						
Percentage of current non-users* who were intended to use contraception in future by preferred method according to place of residence, Andaman & Nicobar Islands, 2002-04						
Future intention to use/method	Women			Husband		
	Total	Rural	Urban	Total	Rural	Urban
Percentage of respondents who intend to use contraceptive in future	41.5	41.0	43.6	48.8	55.5	32.1
Number of non-users	739	619	119	440	314	125
Percent distribution of non-user who were preferred to use family methods by preferred method						
Female sterilization	73.2	71.8	79.9	73.7	74.1	(72.2)
Male sterilization	0.6	0.8	0.0	1.5	0.9	(5.6)
IUD/copper-T/loop	15.8	16.1	14.1	7.7	6.1	(16.7)
Oral pills	7.2	7.9	4.1	3.8	4.6	0.0
Condom/Nirodh	2.0	2.0	2.0	12.6	13.3	(5.6)
Rhythm/periodic abstinence	0.8	1.0	0.0	0.7	0.9	(0.0)
Other	0.4	0.4	0.0	-	-	-
Total percent	100.0	100.0	100.0	100.0	100.0	(100.0)
Number of non-users	306	254	52	215	175	40
Note: * Exclude women who are in menopause or those who have undergone hysterectomy. () based on less than 50 unweighted cases.						

A little less than half of the husbands (49 percent) intended to use contraception in the future, among them 56 percent belong to rural areas, while only 32 percent are from urban areas. Method wise choice in intention to use contraception is again dominated by female sterilization that is being reported by 74 percent, where as only 2 percent preferred male sterilization. Around 13 percent of the husbands preferred Condom/Nirodh, while 8 percent of the husbands preferred IUD/Copper-T/loop and 4 percent preferred Oral Pills.

6.7.2 Future Intentions to use Contraception among Women by Number of Living Children

Table 6.15 provides the information on intention to use contraception in future according to number of living children and residence background in Andaman & Nicobar Islands.

Table 6.15 FUTURE USE OF CONTRACEPTION BY NUMBER OF LIVING CHILDREN						
Percent distribution of currently married women** who were not currently using any contraceptive method by intention to use in the future, according to number of living children and residence, Andaman & Nicobar Islands, 2002-04						
Intention to use in the future	Number of living children					Total
	0	1	2	3	4+	
<i>Total</i>						
Intends to use in next 12 months	5.1	16.3	26.6	25.9	27.5	17.9
One to two years	5.7	8.9	6.7	8.0	17.1	8.2
More than two years	21.1	17.9	9.7	11.1	6.7	15.4
Does not intend to use	20.5	29.6	35.2	43.1	38.0	30.9
Not yet decided	47.6	27.3	21.7	11.8	10.6	27.7
Total percent	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	160	289	159	80	50	739
<i>Rural</i>						
Intends to use in next 12 months	4.6	16.4	24.3	27.9	(24.3)	17.8
One to two years	3.9	8.8	6.3	8.7	(13.5)	8.0
More than two years	21.5	17.2	10.7	11.9	(5.4)	15.3
Does not intend to use	19.7	29.8	35.5	38.7	(43.2)	30.3
Not yet decided	50.4	27.8	23.3	12.7	(13.5)	28.6
Total percent	100.0	100.0	100.0	100.0	(100.0)	100.0
Number of women	130	243	127	75	45	619
<i>Urban</i>						
Intends to use in next 12 months	(6.7)	(15.9)	(34.4)	*	*	18.6
One to two years	(13.3)	(9.1)	(9.4)	*	*	9.1
More than two years	(20.0)	(20.5)	(6.3)	*	*	15.9
Does not intend to use	(23.3)	(29.5)	(34.4)	*	*	33.7
Not yet decided	(36.7)	(25.0)	(15.6)	*	*	22.7
Total percent	(100.0)	(100.0)	(100.0)	*	*	100.0
Number of women	30	46	32	6	5	119

Note: ** Exclude women who are in menopause or those who have undergone hysterectomy. () based on less than 50 unweighted cases. * Percentage not shown – based on very few cases.

Among the current non-users, less than one-fifth of the women (18 percent) intended to use contraception within the next twelve months. Only 8 percent of women wanted to use within one to two years, whereas 15 percent reported their intention to use contraceptives for more than two years. About 28 percent are not sure of their intention to use, whereas 31 percent reported no intention to use. The intention of using contraception is high among the

women who have at least one living child compared to the women who have no living children. Around 48 percent of the women who have no living children reported that they are yet to decide about the use of contraceptives, while 20 percent of the women who have no living children and 30 – 43 percent with one or more living children do not intend to use contraception.

6.8 Reasons for Discontinuation and Non-use of Contraception

Currently married non-pregnant women who were not using any contraceptive method at the time of survey were categorised as past users and never users according to their contraceptive experience. In DLHS-RCH, women who had discontinued contraceptive use were asked about the main reasons for discontinuation. The survey also asked women who had never used contraceptives about the main reasons for not doing so. Table 6.16 shows the main reasons for discontinuation of contraception, while the main reasons for not using contraceptives among both the past never users and current non-users are presented in the next section.

Table 6.16 REASONS FOR DISCONTINUATION OF CONTRACEPTION			
Percent distribution of women who were past users (current non-users) by reasons for discontinuation of the contraceptive methods according to place of residence, Andaman & Nicobar Islands, 2002-04			
Reasons	Total	Place of residence	
		Rural	Urban
Reason for discontinuation			
Wanted child	46.9	39.7	*
Method failed/became pregnant	5.7	8.3	*
Difficult to get method	3.5	1.3	*
Weakness/inability to work	9.9	9.0	*
Body ache/ Backache	3.7	3.4	*
Weight gain	1.9	2.7	*
Breast tenderness	0.4	0.5	*
Irregular periods	1.5	2.2	*
Excessive bleeding	10.1	11.1	*
Lack of pleasure	1.4	2.0	*
Method was inconvenient	9.5	13.8	*
Other	3.4	2.9	*
Missing	2.1	3.1	*
Total percent	100.0	100.0	*
Number of past users	76	52	23

Note: * Percentage not shown – based on very few cases.

Among the past users, around 47 percent of the women mentioned that they discontinued the use because they had wanted a child. ‘Excessive bleeding’, ‘weakness/inability to work’ and ‘method was inconvenient’ (each 10 percent), ‘method failed/became pregnant’ (6 percent) and ‘body ache/backache’ and ‘difficult to get methods’ (each 4 percent) were also reported as main reasons for discontinuation by a sizeable proportion of women.

6.8.1 Reasons for Not Using Contraceptive Methods

DLHS asked women and husbands who are currently not using any contraception about the main reasons why they were not currently using a method (Table 6.17). The reported main reasons for not using contraceptives by the women are 'lack of knowledge about family planning methods' (15 percent), 'health does not permit' (13 percent), 'opposed to family planning' (11 percent), 'worry about side effects' (9 percent), 'afraid of sterilization' (8 percent), 'not like existing method' (6 percent) and 'difficult to become pregnant' (5 percent). About 25 percent of the women reported other reasons for not using contraception. Husbands of the women also reported more or less the same reasons for not using contraception. A sizeable proportion of them (12 percent) also reported the reason 'costs too much' for not using contraception. As far as rural-urban differentials are concerned, variations are observed in the reasons for not using any contraceptive.

Table 6.17 REASONS FOR NOT USING CONTRACEPTIVE METHOD

Percentage of current non-users who were currently not using contraceptive method by reasons according to place of residence, Andaman & Nicobar Islands, 2002-04

Reason	Women			Husband*		
	Total	Rural	Urban	Total	Rural	Urban
Lack of Knowledge about FP method	15.1	15.9	10.4	10.4	15.9	0.0
Against the Religion	2.4	1.8	5.6	6.5	3.2	12.6
Opposed to family planning	11.1	10.2	16.0	19.0	11.4	33.1
Not like existing method	5.6	5.6	6.0	2.1	3.3	0.0
Afraid of sterilization	7.7	7.4	9.5	2.3	2.0	2.8
Can not work after sterilization	2.2	2.3	1.8	2.4	2.0	3.2
Worry about side effects	8.9	10.1	2.6	8.2	6.8	10.8
Costs too much	0.2	0.2	0.0	11.6	17.8	0.0
Health does not permit	12.7	13.0	11.0	1.8	1.3	2.8
Hard/inconvenient to get method	2.0	1.6	3.8	3.3	0.9	7.6
Inconvenient to use method	1.2	0.9	2.6	0.0	0.0	0.0
Difficult to become pregnant	4.7	4.6	5.0	10.8	9.2	13.8
Wife is pregnant ¹	-	-	-	5.1	6.9	1.7
Other	25.4	25.6	24.6	16.6	19.3	11.6
Missing	0.8	0.8	1.0	0.0	0.0	0.0
Total percent	100.0	100.0	100.0	100.0	100.0	100.0
Number of current non-users	464	391	74	226	147	79

Note: ¹ Not applicable for women. * Excluding not decided cases on timing of next child.

6.9 Unmet Need for Family Planning Services

Unmet need for family planning is one of the indicators to assess the effectiveness of the family planning programme. Policy makers and family planning programme planners use this to know the demand for family planning services/supplies. Unmet need is defined in this report separately for limiting and spacing. Unmet need for spacing includes the proportion of currently married women who are neither in menopause nor had hysterectomy nor are currently pregnant and who want more children after two years or later and are currently not using any family planning method. The women who are not sure about whether and when to have next child, are also included in unmet need for spacing. Unmet need for limiting includes the proportion of currently married women who are neither in menopause nor had hysterectomy nor are currently pregnant and do not want any more children but are currently not using any family planning method. Total unmet need refers to the totality of unmet for limiting and spacing. Table 6.18 provides the information about unmet need for limiting and spacing in Andaman & Nicobar Islands by background characteristics.

The unmet need is high for women below 25 years (28-37 percent), mostly for spacing rather than for limiting. Among the women of age 25-29 years, 26 percent have unmet need, and more or less the same for spacing and for limiting. Among the older women age 30 years and above, unmet need is also, mostly for limiting. The rural women have slightly more unmet need (27 percent) than the urban women (23 percent). The unmet need for family planning is slightly higher among non-literate women (29 percent) than among the women with 0-9 years of schooling (26 percent) and the women with 10 or more years of schooling (25 percent). Muslim (25 percent) and Hindu (23 percent) women have lesser unmet need for family planning compared to Christian women (30 percent). Unmet need for family planning is high for Scheduled caste women (36 percent) followed by Scheduled tribe (27 percent) and 'other castes' category (25 percent) women.

Women in low (30 percent) and medium (27 percent) standard of living have relatively higher unmet need than the women of high standard of living (23 percent). Unmet need is much higher for the women with one living child (39 percent) followed by women with four or more children (28 percent). Among the women with no children or one child, the unmet need is mostly for spacing, whereas for women with two or more children, unmet need is more for limiting.

Table 6.18 UNMET NEED FOR FAMILY PLANNING SERVICES
 Percentage of currently married women with unmet need for family planning services by selected background characteristics, Andaman & Nicobar Islands, 2002-04

Background Characteristic	Unmet need for FP			Number of women
	Spacing ¹	Limiting ²	Total	
Age				
15-19	(25.6)	(2.6)	(28.2)	48
20-24	25.6	11.0	36.5	300
25-29	12.9	13.1	25.9	531
30-34	7.7	20.8	28.5	383
35-39	3.5	14.0	17.5	299
40-44	1.8	18.6	20.4	220
Residence				
Rural	11.7	14.9	26.6	1,467
Urban	8.4	14.9	23.4	315
Education				
Illiterate	7.4	21.3	28.7	392
0-9 @ years	12.8	12.9	25.7	866
10 years and above	11.2	13.5	24.6	524
Religion				
Hindu	9.7	13.6	23.3	915
Muslim	6.8	18.5	25.4	138
Christian	14.3	15.8	30.1	704
Others	0.0	18.2	18.2	26
Caste/tribe#				
Scheduled caste	16.2	20.1	36.3	187
Scheduled tribe	13.0	12.7	25.7	517
Other backward class	(6.0)	(6.0)	(12.0)	38
Others	9.6	15.4	25.0	925
Number of living children				
0	19.5	1.2	20.7	168
1	29.5	9.5	39.0	430
2	4.0	17.4	21.4	673
3	1.6	19.4	21.0	353
4+	4.2	23.5	27.6	158
Standard of living Index				
Low	14.3	16.1	30.4	429
Medium	12.3	14.3	26.6	629
High	8.3	14.7	23.1	724
All women	11.2	14.9	26.0	1,782
Note: ¹ Unmet need for spacing includes the proportion of currently married women who are neither in menopause or had hysterectomy nor are currently pregnant and who want more children after two years or later and are currently not using any family planning method. The women who are not sure about whether and when to have next child are also included in unmet need for spacing. ² Unmet need for limiting includes the proportion of currently married women who are neither in menopause or had hysterectomy nor are currently pregnant and do not want any more children but are currently not using any family planning method. Total unmet need refers to unmet for limiting and spacing. @ Literate women with no years of schooling are also included. # The total figure may not add to N due to do not know and missing cases. () based on less than 50 unweighted cases.				

6.9.1 Unmet Need for Family Planning Services by Districts

Table 6.19 provides the information about unmet need for limiting, spacing and total by district.

Table 6.19 UNMET NEED BY DISTRICTS			
Percentage of currently married women with unmet need by district, Andaman & Nicobar Islands, 2002-04			
Districts	Unmet need for		
	Spacing	Limiting	Total
Andamans	10.6	15.0	25.7
Nicobars	11.5	14.6	26.0
Andaman & Nicobar Islands	11.2	14.9	26.0

The unmet need for family planning services for the union territory is 26 percent and it is almost the same in Andamans and Nicobars districts. It may also be observed that in both the districts, the unmet need for limiting was slightly more than spacing.

CHAPTER VII

ACCESSIBILITY AND PERCEPTION ABOUT GOVERNMENT HEALTH FACILITIES

The government health facilities at all the levels provide various RCH services. Auxiliary Nurse Midwife (ANM), female health worker or male health worker play a key role in delivering the health services to the community. Health workers are expected to make regular visits to all the households in their assigned area. During these contacts, the health workers are supposed to monitor various aspects of the health of women and children, provide information related to health and family planning, counsel and motivate to adopt appropriate health and family planning practices, and deliver other selected services. These contacts are also important as they enhance the creditability of the services and establish necessary rapport with the clients. In order to assess the extent of utilisation of government health facilities by all eligible women and to find out whether ANMs/health workers reach the households for providing RCH services, a separate section in the women's questionnaire was canvassed to all the eligible women. This chapter deals with the accessibility and the opinion of women about the services provided by the government health workers. The quality of care offered by the government health programme as perceived by currently married women is also presented.

7.1 Home Visits by Health Workers

Table 7.1 shows the percentage of currently married women visited by health workers at home during three months prior to the survey by selected background characteristics. Only 9 percent of the women in Andaman & Nicobar Islands reported that the health workers visited them at their residence at least once in last three months preceding the survey. More or less the same proportion of younger and older women reported home visits. The percentage of women receiving home visits is relatively higher in rural areas (11 percent) than in urban areas (2 percent). There are marginal differences in the proportion of women reporting home visits of health workers by their educational background and standard of living index. Slightly more Christian women (11 percent) reported home visits than Hindu (8 percent) and Muslim (7 percent) women. Home visits of health workers are reported slightly more by women belonging to scheduled tribes (11 percent) and scheduled castes (9 percent) than 'other castes' category women (7 percent). Home visits were reported by relatively more proportion of women residing in the villages with no health facility than those from the villages with health facility.

Women who reported a home visit during three months preceding the survey were asked about the health personnel who visited their households during the past three months and whether they were satisfied with the kind of services/advices received, and the time spent by these health workers. Among women who received services/advices at home, 99 percent received services/advices from ANM/LHV, one percent from male health worker and less than one percent from a doctor. Around 87 percent of women who received services at home were satisfied with the amount of time spent with them by health workers and 92 percent of women were satisfied with the services or advice given to them.

Table 7.1 HOME VISIT BY HEALTH WORKER

Percentage of women who had home visit by a doctor, ANM/LHV, or male health worker during 3 months preceding the survey and among women who had home visits, satisfied with time spent by health workers and with services provided by selected background characteristics, Andaman & Nicobar Islands, 2002-04

Background characteristic	Percentage with home visit	Number of women	Home visit by ¹			Percentage of women satisfied with		
			Doctor	ANM / LHV	Male health worker	Amount of time	Services/advices	Number of women
Age								
15-24	7.8	348	(0.0)	(97.0)	(3.0)	(87.9)	(90.9)	27
25-34	9.1	915	0.0	100.0	0.0	85.0	92.9	83
35-44	10.3	519	0.5	98.7	1.3	86.9	89.0	53
Residence								
Rural	10.6	1,467	0.2	99.0	1.0	86.8	92.1	156
Urban	2.3	315	*	*	*	*	*	7
Education								
Non-literate	7.9	392	(2.7)	(100.0)	(0.0)	(83.8)	(94.6)	31
0-9 years@	9.9	866	0.0	99.2	0.8	85.7	90.8	86
10 and above	8.9	524	(0.0)	(98.2)	(1.8)	(87.7)	(89.5)	47
Religion								
Hindu	8.3	915	0.0	99.1	0.9	89.2	91.4	76
Muslim	7.4	138	*	*	*	*	*	10
Christian	10.7	704	0.3	98.8	1.2	85.7	94.5	76
Other	(12.5)	26	*	*	*	*	*	1
Caste/tribe#								
Scheduled caste	9.1	187	*	*	*	*	*	17
Scheduled tribe	11.1	517	0.4	100.0	0.0	92.5	96.1	57
Other backward class	(6.0)	38	*	*	*	*	*	4
Other	7.2	925	0.0	99.0	1.0	82.9	87.3	66
Standard of living index								
Low	9.0	429	(0.0)	(100.0)	(0.0)	(81.8)	(90.9)	39
Medium	10.0	629	0.0	98.6	1.4	87.2	89.7	63
High	8.5	724	0.4	98.9	1.1	89.0	92.0	62
Availability of health facility ² in the village								
No	14.7	339	0.0	100.0	0.0	81.6	94.7	50
Yes	9.4	1,128	0.2	98.5	1.5	89.3	90.9	106
Total	9.2	1,782	0.2	99.0	1.0	86.7	91.7	163

Note: ¹ Percentage add to more than 100.0 due to multiple responses. @ Literate women with no years of schooling are also included. # Total number may not add to N due to do not know and missing cases. ² Includes sub-center, primary health center, Community health center or referral hospital, government hospital, and government dispensary within the village. () based on less than 50 unweighted cases. * Percentage not shown – based on very few cases.

The proportion of women who were satisfied with the amount of time spent, and services/advices provided by health workers did not vary much across various background characteristics. Scheduled caste women were more likely to report that they were satisfied with amount of time spent by health workers during home visits and also, with the services/advices received.

7.2 Home Visits by Health Workers by Districts

In the two districts in Andaman & Nicobar Islands, health workers visited less women at home (Table 7.2 and Figure 7.1). In Andamans district, 8 percent of the women were visited by health workers, while 10 percent of the women received home visits in Nicobars district. Among women who were visited by health worker at home, all of them in Nicobars and most of them in Andamans (98 percent) were approached by ANM/LHV. None of the women were approached by male worker at home in Nicobars district and around 3 percent were approached in Aandamans district, while the proportion of women visited by doctor at home was below one percent in Nicobars district and none in Andamans district.

In both the districts, more than four-fifths of the women said that the health worker had spent enough time with them. Also, 87 percent of the women in Andamans and 95 percent in Nicobars reported satisfaction with services/advices given by health workers.

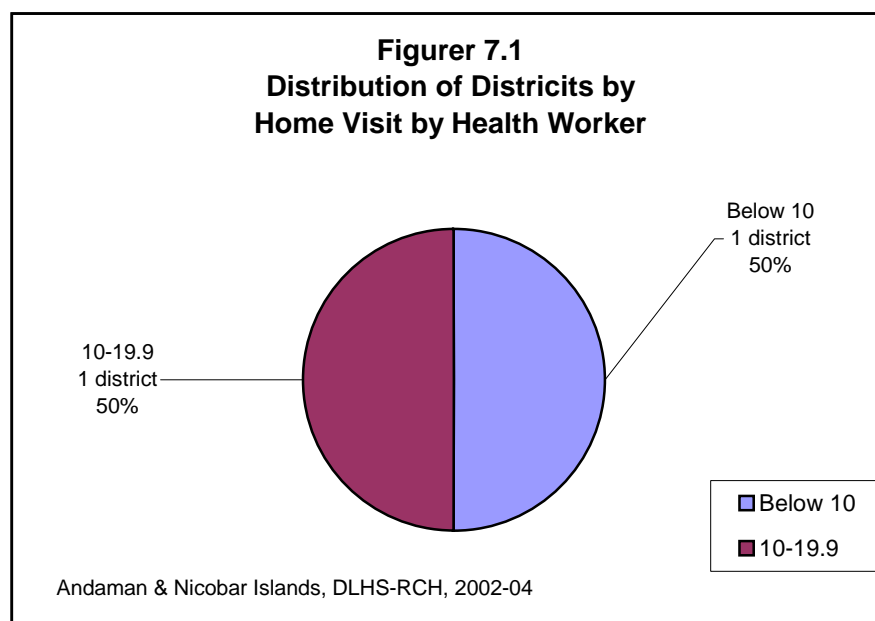


Table 7.2 HOME VISIT BY HEALTH WORKER BY DISTRICT

Percentage of women who had home visit by a doctor, ANM/LHV, or male health worker in the 3 months preceding the survey, among women who had home visit, satisfied with time spent by health workers and with services/advices provided by district, Andaman & Nicobar Islands, 2002-04

District	Percentage with home visit	Home visit by ¹			Percentage of women satisfied with	
		Doctor	ANM / LHV	Male health worker	Time spent	Services
Andamans	7.9	0.0	97.5	2.5	81.7	86.9
Nicobars	10.3	0.3	100.0	0.0	90.8	95.1
Andaman & Nicobar Islands	9.2	0.2	99.0	1.0	86.7	91.7

Note: ¹ Percentage add to more than 100.0 due to multiple responses.

7.3 Matters Discussed during Home visits or Visits to Health Facilities

Women who were visited at home by a health worker, as well as those who visited government health facility or other health facility during three months preceding the survey were asked about the different topics discussed with the health workers during any of these visits. Table 7.3 shows the percentage of women who discussed the health and family planning or any health related matters with the health workers during home visits or visits to a health facility during the past three months. There are 64 pregnant woman or women with children born during the reference period, and other women includes 73 current users and 26 current non-users, who were visited by health workers at home.

Table 7.3 MATTER DISCUSSED DURING CONTACT WITH A HEALTH WORKER				
Percentage of women who were visited by health worker in three months preceding the survey, and women who visited health facility, and the women ¹ who discussed specific topics with the health worker, Andaman & Nicobar Islands, 2002-04				
Topic discussed	Pregnant women or women with children after reference period ²	Other women		Total
		Current contraceptive users	Current nonusers	
During home visit				
Family planning	48.3	16.5	(45.5)	33.7
Breastfeeding	38.6	1.2	(6.1)	17.0
Supplementary feeding	29.4	1.4	(9.1)	13.7
Immunization	43.8	10.1	(9.1)	23.4
Nutrition	45.3	27.8	(39.4)	38.7
Diseases prevention	44.0	60.7	(48.5)	53.8
Treatment of health problem	35.8	41.9	(48.5)	42.1
Antenatal care	12.3	4.0	(3.0)	7.3
Delivery care	7.7	4.5	(3.0)	5.7
Postpartum care	8.4	4.5	(0.0)	5.3
Childcare	34.0	19.0	(12.1)	23.8
Sanitation / cleanliness	41.0	52.1	(39.4)	46.9
Oral rehydration	31.9	18.9	(36.4)	27.0
Other	6.6	10.6	(18.2)	9.9
Number of women	64	73	26	163
During visit to health facility				
Family planning	15.1	5.2	(2.2)	9.9
Breastfeeding	14.1	1.1	(2.2)	7.8
Supplementary feeding	8.8	0.7	(0.0)	4.7
Immunization	25.1	2.6	(4.4)	14.2
Nutrition	17.5	7.2	(6.7)	12.2
Diseases prevention	17.9	16.3	(20.0)	17.7
Treatment of health problem	39.5	70.3	(66.7)	55.1
Antenatal care	26.0	2.6	(4.4)	14.7
Delivery care	10.0	0.0	(8.9)	6.0
Postpartum care	6.3	0.0	(0.0)	3.2
Childcare	25.3	8.7	(6.7)	18.0
Sanitation / cleanliness	9.6	13.5	(2.2)	9.6
Oral rehydration	8.7	6.9	(6.7)	7.5
Other	2.2	7.5	(13.3)	5.1
Number of women	160	109	47	316
Note: Percentage add to more than 100.0 due to multiple responses. ¹ Women who visited private health facility are not included. ² Reference period for phase I, January 1 st 1999 and for phase II, January 1 st .2001. () based on less than 50 unweighted cases.				

The major focus of discussions during home visits with pregnant women and women with children during reference period was on family planning (48 percent), nutrition (45 percent), immunization and disease prevention (each 44 percent), sanitation/cleanliness (41 percent), breast feeding (39 percent), treatment of health problems (36 percent), childcare (34 percent), oral rehydration (32 percent) and supplementary feeding (29 percent). In addition, discussions were also made on antenatal care (12 percent) and post-partum care and delivery care (each 8 percent). Discussions about disease prevention and treatment of health problems were mentioned more often by current contraceptive users and current non-users than pregnant women or women with children born during reference period. As expected, pregnant women or women with children born during reference period were much more likely than other women to report that they discussed childcare, immunization, nutrition, supplementary feeding and breastfeeding. A higher proportion of current contraceptive users and current non-users discussed disease prevention, sanitation and cleanliness and treatment of health problems during home visits by health workers during past three months preceding the survey.

The topics discussed most often during visits to health facility by women were treatment of health problems (55 percent), disease prevention and child care (each 18 percent), antenatal care (15 percent), immunization (14 percent) and nutrition (12 percent). Only 10 percent women reported that they discussed family planning during the visit. During visit to health facility about 39 percent of the pregnant women or women with children born during reference period discussed about treatment of health problems, 26 percent discussed about antenatal care and 25 percent each discussed about immunization and child care. A sizeable proportion of these women also discussed about disease prevention, nutrition, family planning, and breast feeding during visits to health facility. A higher proportion of current users and non-users discussed about treatment of health problems than pregnant women and women with children born during reference period during visits to health facility in three months prior to survey.

7.4 Visits to Health Facility

Table 7.4 presents the percentage of currently married women who needed to visit health facility and visited the health facility by residence and availability of health facility in the village.

Table 7.4 VISIT TO HEALTH FACILITY

Percentage of women who need to visit health facility and visited, and percent distribution of women who visited health facility by type of health facility and according to place of residence and availability of health facilities in the village, Andaman & Nicobar Islands, 2002-04

Health facility	Total	Residence		Availability of health facility ¹ in the village	
		Rural	Urban	No	Yes
Percentage of women who needed to visit health facility and not visited	18.3	19.6	12.1	12.8	21.7
Percentage of women who needed to visit health facility and visited	18.3	18.7	16.0	19.3	18.6
Number of women	1,782	1,467	315	339	1,128
Government health facility					
Hospital / CHC / FRU / RH	31.1	22.8	76.3	21.1	23.3
Dispensary	1.0	1.2	0.0	0.0	1.6
Primary health center	49.2	57.0	6.5	56.1	57.3
Sub-center	14.7	15.9	8.1	14.5	16.3
Private health facility					
Hospital	2.0	2.0	2.0	6.3	0.7
Dispensary	0.2	0.3	0.0	0.0	0.4
ISM ² hospital/dispensary	1.2	0.7	3.4	2.0	0.4
Other	0.6	0.0	3.8	0.0	0.0
Total percent	100.0	100.0	100.0	100.0	100.0
Number of women	325	275	50	65	210

Note: CHC: Community health center, FRU: First referral unit, RH: Referral Hospital. ¹ Includes sub-center, primary health center, Community health center or referral hospital, government hospital, and government dispensary within the village. ² Either government or private health facility of Indian System of Medicine.

Around 18 percent of the women who needed to visit health facility did not visit and a similar proportion of the women visited a health facility in past three months of the survey. The proportion of such women was slightly higher in rural areas (19 percent) than in urban areas (16 percent). Among them who visited any health facility, 96 percent of women reported that they had visited a government health facility, 97 percent in rural areas and 91 percent in urban areas.

Among the women who visited a government health facility, 49 percent visited primary health centre, 31 percent visited government health facility such as, hospital/CHC/FRU/RH and 15 percent visited sub-centres. Only 2 percent of the women reported that they visited a private hospital/dispensary. One percent of the women reported that they visited Indian system of medicine hospital/ dispensary either government or private. There are not much differences in visits to any health facility according to availability of health facility in the village in the past three months of the survey.

7.5 Visits to Health Facility by Districts

Table 7.5 presents the percentage of currently married women who needed to visit health facility and visited and not visited a health facility by districts.

Table 7.5 VISIT TO HEALTH FACILITY BY DISTRICT				
Percentage of women who needed to visit health facility, but not visited and percentage of women who visited health facility by type of health facility by district, Andaman & Nicobar Islands, 2002-04				
Districts	Percentage of women who need to visit health facility, but not visited	Percentage of women who need to visit health facility and visited	Percentage of women who visited to	
			Government health facility	Private health facility
Andamans	12.7	23.3	95.4	3.7
Nicobars	23.7	13.2	98.5	1.5
Andaman & Nicobar Islands	18.3	18.3	96.6	2.8

A relatively higher proportion of currently married women in Nicobars (24 percent) who needed to visit a health facility did not visit as compared to those in Andamans (13 percent). In contrast, a relatively higher proportion of the women in Andamans (23 percent) than in Nicobars (13 percent) visited health facility for their health problems. Among them who visited health facility, most of the women in Andamans (95 percent) and Nicobars (99 percent) visited government health facility in past three months of the survey.

7.6 Clients' Perception of Quality of Government Health Services

Utilization of services is an essential indicator reflecting the quality of services. Better quality of services would have a higher utilization rate, which is very important from the policy point of view. Unless clients are satisfied with the services provided by the government, efforts made by the government will be wasted. In order to assess the utilization of government health facilities, a question was asked whether they had visited any health facility for their health problem during past three months prior to the date of survey. Those who visited the government health facility were asked their perceptions about quality of services (personal manner like courtesy, respect, sensitivity, and friendliness of the physician and staff and their technical skills and quality like thoroughness, carefulness, and competence and waiting time for receiving the services) and the same are presented in Table 7.6.

Table 7.6 QUALITY OF GOVERNMENT HEALTH FACILITY			
Percentage of women who visited government health facility and rated quality and availability of services during most recent visit to a government health facility in the three months preceding the survey, Andaman & Nicobar Islands, 2002-04			
Quality indicator	Poor	Good	Excellent
The convenience of the health facility location	11.1	83.0	5.9
Length ¹ of time spend towards waiting	27.5	68.3	4.2
Personal manner ² of the physician ⁵	2.6	89.0	8.4
The technical skills and quality ³ of the physician ⁵	2.9	90.7	6.4
Personal manner ² of nurse	3.7	90.7	5.6
The technical skills and quality ³ of nurse	3.3	91.5	5.2
Personal manner of other staff ⁵	3.6	90.2	6.2
The technical skills and quality of other ⁴ staff	4.7	79.8	5.7
The explanation of what was done to her	3.6	92.8	3.6
Medical, surgical and diagnostic equipment	3.2	94.1	2.7
General comfort	4.1	93.0	2.8

Note: ¹ Poor indicate long waiting time, good indicate average waiting time, and excellent indicate short waiting time. ² Courtesy, respect, sensitivity, friendliness. ³Thoroughness, carefulness, competence. ⁴Including paramedical staff. ⁵Includes hospital/community health center/ first referral unit/ referral hospital, dispensary, and primacy health center last visit made by women.

Women in general perceived that the quality of services, personal manner as well technical skills and quality of physician, ANM/nurse and other staff was good. Majority of the respondents perceived that personal manner (courtesy, respect, sensitivity, and friendliness) and technical skills (thoroughness, carefulness, and competence) of the physician, nurses and other staff were good, while a sizeable proportion of the respondents mentioned 'long waiting time at the centre' (28 percent), and 'inconvenient location of the centre' (11 percent) as problems in receiving the services.

7.7 Family Planning Information and Advice Received

Women who are currently not using any contraceptive method were asked whether they were ever advised by ANM or family planning health worker to adopt family planning methods and about the methods advised during any of the contact. Around 44 percent of current non-users said that they had advices or discussion on methods of family planning with ANM or family planning health worker (Table 7.7). The frequently discussed method was female sterilization (49 percent) followed by IUD (33 percent). Only 2 percent of women received advices to adopt male sterilization, 8 percent to adopt Pills and 6 percent to adopt Condom as contraceptive methods. Discussion about other methods was rare. There is not much variation in the proportion of women who reported receipt of advice on family planning by type of residence. However, there is difference in the pattern of family planning method information by type of residence. A slightly higher proportion of the women in urban areas was reported to be advised to adopt IUD (47 percent) than the female sterilization (45 percent), while the opposite is the case with women from rural areas. Also, none of the urban women reported receipt of advice on male sterilisation.

Table 7.7 ADVISE TO ADOPT FAMILY PLANNING METHOD			
Percentage of current non-users who reported ever advised to adopt family planning method by method of family planning by ANM/health worker, according to residence, Andaman & Nicobar Islands, 2002-04			
Method	Total	Rural	Urban
Percentage of non-users who were advised to adopt family planning method	43.9	44.1	43.1
Number of women	739	619	119
Method			
Female sterilization	48.7	49.5	44.7
Male sterilization	1.9	2.3	0.0
IUD	32.9	30.4	46.5
Pills	8.2	8.6	6.5
Condom	6.1	6.8	2.3
Other	2.1	2.5	0.0
Total percent	100.0	100.0	100.0
Number of women	324	273	51

7.8 Availability of Pills and Condoms

To explore difficulties faced in the procurement of condoms and pills, current users of these methods were asked whether they had been able to get their supplies whenever needed. The results are presented in Table 7.8. Only 11 percent of condom users and less than one percent of pills users reported that they had a problem in getting these methods.

Table 7.8 AVAILABILITY OF REGULAR SUPPLY OF CONDOMS/PILLS		
Percentage of current condom or pill users who ever had a problem getting suppliers of condoms/pills by residence, Andaman & Nicobar Islands, 2002-04		
Method/residence	Percentage who had a problem getting supply	Number of users
Condom		
Rural	10.7	54
Urban	*	8
Total	10.9	62
Pills		
Rural	1.4	47
Urban	(0.0)	26
Total	0.9	73
Note: * Percentage not shown – based on very few cases. () Based on less than 50 unweighted cases.		

7.9 Quality of Care of Family Planning Services

Several aspects of quality of care of family planning services were also investigated. Current users of sterilization were asked whether the persons or centres where sterilization had been performed, informed them about other alternative methods of family planning; and further it was asked whether they were told by ANM or health worker about possible side effects of the modern methods at the time they accepted the methods; whether they received any follow-up care after accepting the methods. Tables 7.9 and 7.10 present the results of this investigation.

Table 7.9 INFORMATION OF OTHER MODERN METHODS BEFORE STERILIZATION				
Percentage of current users of sterilization who were informed about other modern method by the source where they get sterilized, according to the source of sterilization and residence, Andaman & Nicobar Islands, 2002-04				
Source of sterilization	Total	Rural	Urban	Number of users
Government health facility	47.1	46.7	49.2	794
Total	47.7	47.3	50.1	817
Note: Total includes 8, 13, 1 and 1 women who said that they sterilized at Family planning camp/village session, Private health facility, Mobile clinic and other, and who do not know including missing information of place/source of sterilization, were not shown separately.				

Around 48 percent of sterilized women reported that ANM or health worker informed them about alternative methods that they could use before adopting sterilization (Table 7.9). Almost all the sterilized women (47 percent) received such information in the government health facilities at the time of accepting the sterilization.

Another important facet of informed contraceptive choice is being fully informed about any side effects and any other problems associated with the method use. In Andaman & Nicobar Islands, a little more than half of users of any modern method (51 percent) were informed about possible side-effects or health problems associated with their current method (Table -10). Around 46 percent of acceptors of sterilization in rural areas and 52 percent in urban areas reported that they were informed about side-effects. Among users of modern methods other than sterilization, as many as 70 percent of rural users and 48 percent of urban users were informed about side-effects. It is clear from the results that ANMs or health workers in Andaman & Nicobar Islands are providing sufficient information to couples who need to make an informed choice about contraceptive methods. However, the situation with respect to follow-up services is not encouraging. Follow-up services among sterilization users are slightly lower (18 percent) than among the users of other modern methods (21 percent). About 19 percent of sterilization users in rural areas and 12 percent in urban areas reported that they received follow-up services by ANMs or health workers. Around 26 percent of the users of modern methods other than sterilization in rural areas and only 10 percent in urban areas received follow-up services.

Table 7.10 INFORMATION ON SIDE EFFECTS AND FOLLOW-UP FOR CURRENT METHOD

Percentage of current users of modern contraceptive methods who were told about side effects or other problems of current method by a health worker or ANM/Nurse at the time of accepting the method and percentage who received follow-up services after accepting the method by current method and residence, Andaman & Nicobar Islands, 2002-04

Information/follow-up	Total	Rural	Urban
Told about side effects			
Sterilization	47.3	46.4	52.3
Other modern method	63.7	70.2	48.3
Any modern method	50.6	50.5	51.1
Received follow-up			
Sterilization	18.0	19.1	12.3
Other modern method	21.2	26.2	9.8
Any modern method	18.6	20.3	11.5

7.10 Quality of Care Indicators for Contraceptive Users by Districts

Table 7.11 shows inter-district variations in the percentage of users of sterilization who were told about alternative methods before adopting sterilization and about side-effects or other problems related to the current users of modern contraceptive methods, and the percentage of users who received follow-up services.

Table 7.11 QUALITY OF CARE INDICATORS FOR CONTRACEPTIVE USERS BY DISTRICT

Percentage of currently married women who are current users of modern contraceptive methods by quality of care indicators related to the use of their current contraceptive method by district, Andaman & Nicobar Islands, 2002-04

District	Percentage informed about other methods before getting sterilization ¹	Percentage told about side effects or other problems with method ²		Percentage who received follow-up ²		Percentage non-user told ever had advised to adopt contraceptive method
		Sterilization	Other modern method	Sterilization	Other modern method	
Andamans	48.5	49.2	59.3	13.5	9.8	47.8
Nicobars	46.7	45.0	73.7	22.0	42.3	40.5
Andaman & Nicobar Islands	47.7	47.3	63.7	18.0	21.2	43.9

Note: ¹ At the time of accepting the current method. ² By a health worker or ANM/Nurse after accepting the current method.

The percentage of sterilization-users who were told about alternate methods is slightly more in Andamans (49 percent) than in Nicobars (47 percent). There is also minor difference in the percentage of sterilization - users who were told about the possible side-effects in the two districts, however, there is large variation in the case of users of other modern contraceptive methods. In case of sterilization, the proportion is slightly higher in Andamans (49 percent) than in Nicobars (45 percent). In contrast, as many as 74 percent of users of modern contraceptive methods other than sterilization in Nicobars district were told about possible side effects, while it is 59 percent in Andamans district. Follow-up services are relatively better for acceptors of sterilization and other modern methods in Nicobars district than in Andamans. Table 7.11 also shows district-wise variation in the percentage of current non-users who were ever advised to adopt contraceptive methods, which is relatively higher in Andamans (48 percent) than in Nicobars (41 percent).

Overall, the quality of care for family planning and health services is satisfactory in both the districts of Andaman & Nicobar Islands; however, both the districts need to work more to improve their health and family planning services, particularly follow-up services.

7.11 Quality of Care of Maternal Health Care

Information on few other aspects of quality of care in terms of maternal care was also collected. Women with last live/still births during three years preceding the survey were asked whether the Doctor/ANM/health worker advised them to go to health facility for delivery when they were pregnant, and received any follow-up care after delivering the baby within 2 weeks of delivery and received follow-up care at least once within six weeks of delivery. The same information is presented in Table 7.12.

Table 7.12 ADVISED TO HAVE DELIVERY AT HEALTH FACILITY AND FOLLOW-UP SERVICES FOR POSTPARTUM CHECK-UPS			
Percentage of women* who were advised to have delivery at health facility by doctor/ health worker and percentage who received follow-up services within 2 weeks and within 6 weeks of delivery by ANM, according to residence, Andaman & Nicobar Islands, 2002-04			
Advise/follow-up service	Total	Rural	Urban
Percentage of women who were advised to have delivery at health facility	82.7	84.0	76.8
Percentage of women who were visited within 2 weeks of delivery	17.2	18.5	11.1
Percentage of women who were visited at least once within 6 weeks of delivery	20.2	22.3	11.1
Number of women	703	572	131
Note: * Women who had their last live/still birth after 1.1.1999/1.1.2001.			

More than four-fifths of the women with last live/still births during three years preceding the survey (83 percent) reported that they were advised by doctor or health worker to have delivery in health facility. A relatively lesser proportion of the women from urban areas (77 percent) were advised to deliver their children at health facility as compared to their rural counterparts (84 percent).

In district-wise variation, the percentage is relatively lower in Andamans (76 percent) than in Nicobars district (88 percent) (Table 7.13).

Table 7.13 QUALITY OF CARE INDICATORS FOR MATERNAL CARE BY DISTRICT			
Percentage of currently married women* who are given live/still births among three years preceding the survey by quality of care indicators related to delivery care by district, Andaman & Nicobar Islands, 2002-04			
District	Percentage of women		
	Advised to have delivery at health facility by doctor/ health worker	Visited within 2 weeks of delivery by ANM	Visited at least one within 6 weeks of delivery by ANM
Andamans	77.5	14.7	15.5
Nicobars	88.0	20.3	25.7
Andaman & Nicobar Islands	82.7	17.2	20.2

Note: * Women who had live birth/still birth after 1.1.1999/1.1.2001.

Only 17 percent of the women reported that they were visited by an ANM within two weeks of delivery; such visit was 11 percent in urban areas and 19 percent in rural areas. Only 22 percent of the women in rural areas and 11 percent in urban areas received at least one follow-up service within six weeks of delivery (Table 7.12). A relatively higher proportion of women in Nicobars district (20-26 percent) had received postpartum check-ups within 2 weeks of delivery and at least one postpartum check-up within six weeks of delivery as compared to those in Andamans district (15-16 percent) (Table 7.13).

CHAPTER VIII

REPRODUCTIVE HEALTH PROBLEMS AND AWARENESS OF RTIs/STIs AND HIV/AIDS

One of the important components of the Reproductive and Child Health Programme is to have a healthy sexual life without any fear of contracting disease. With this approach the RCH programme places a lot of emphasis on promoting and encouraging healthy sexual behaviour among couples through various Information, Education and Communication (IEC) activities. Health workers are also expected to educate women and men about Reproductive Tract Infections (RTIs) and Sexually Transmitted Infections (STIs) and motivate those people with RTI/STI problems to seek medical help. The DLHS-RCH has made an attempt to collect information on awareness and prevalence of RTI/STI. Apart from this, information on knowledge of HIV/AIDS, source of information and way of avoiding AIDS was also collected.

8.1 Awareness of RTI/STI

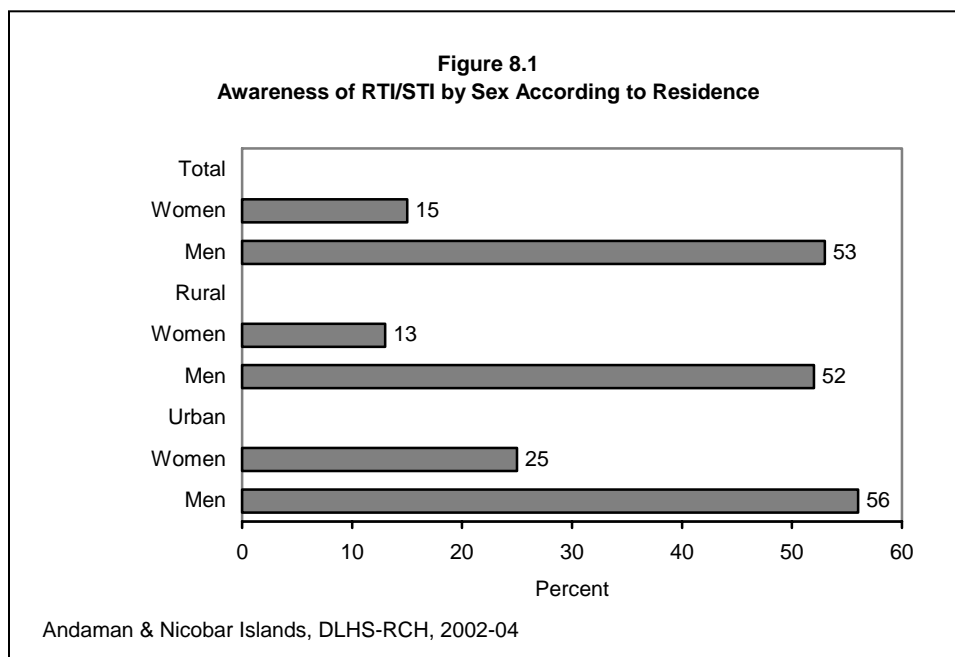
An attempt was made to assess whether couples were aware of RTI/STI. Currently married women and their husbands were asked about their awareness of RTI/STI, and if they were aware, they were further questioned about the source of information and mode of transmission of the disease.

Table 8.1 shows the percentage of women aware of RTI/STI by background characteristics. Only 15 percent of the women in Andaman & Nicobar Islands were aware of RTI/STI. The proportion of women who were aware of RTI/STI is relatively higher in urban areas (25 percent) than in rural areas (13 percent) (Figure 8.1). Awareness of RTI/STI is much lower among non-literate women, women from Christian religion, scheduled tribe women and women from households with a low standard of living. Awareness of RTI/STI increases from 5 percent among non-literate women to 29 percent among women who have completed 10 or more years of schooling. The standard of living index shows a positive relationship with awareness of RTI/STI, ranging from 7 percent among women with a low standard of living to 24 percent among women with a high standard of living.

Those women who had heard of RTI/STI were further asked about the source of information of RTI/STI, which is presented in Table 8.1. A little more than four-fifths of the women (81 percent) reported that they had heard of RTI/STI through television followed by radio (76 percent) and newspaper or books or magazines (66 percent). Other sources of information on RTI/STI as reported by women were friends or relative (48 percent), health workers (42 percent), slogans or posters or pamphlets or wall hoardings (31 percent), doctors (23 percent), community meetings (18 percent) and school teacher (11 percent).

Table 8.2 shows the percentage of husbands of currently married women who heard of RTI/STI by specific source of information according to some selected background characteristics. In Andaman & Nicobar Islands, the percentage of men who heard of RTI/STI

is much higher than that of women (Figure 8.1). Fifth-three percent of the men heard of RTI/STI. Men from urban areas and younger men were slightly more aware of RTI/STI. Men who belong to Christian religion and mainly from scheduled tribes are less likely to report awareness of RTI/STI. The level of awareness of RTI/STI increases sharply with an increase in education level, while it is not exactly so in the case of standard of living. Around 13 percent of non-literate men were aware of RTI/STI as compared to 74 percent of men who had completed 10 or more years of schooling. Around two-fifths of men from households with a low (41 percent) or medium (38 percent) standard of living were aware of RTI/STI as compared to 68 percent of men with a high standard of living.



Television and radio are the most prominent sources of RTI/STI for men in Andaman & Nicobar Islands. Around four-fifths of men who knew about RTI/STI received information through television (81 percent) and radio (80 percent). Other important sources of information about RTI/STI are health workers (45 percent), newspaper or books or magazines (40 percent) and slogans or posters or pamphlets or wall hoardings (39 percent), followed by relatives or friends (30 percent) and doctor (18 percent). About 13 percent of the men received this information from community meetings and 6 percent mentioned that they had received information about RTI/STI from school-teachers. Three percent of the men reported that they heard of RTI/STI from other sources. Television or radio are the most important sources of information on RTI/STI in all the groups. Men from rural areas, Christian men, and men with a low standard of living are relatively less prone to receive information from television or radio. The differences in the knowledge of RTI/STI from television or radio as sources of

Table 8.1 SOURCE OF KNOWLEDGE ABOUT RTI/STI AMONG WOMEN

Percentage of currently married women age 15 - 44 who have heard about RTI/STI and among women who have heard about RTI/STI, percentage who received information from specific sources by selected background characteristics, Andaman & Nicobar Islands, 2002-04.

Background Characteristic	Percentage who have heard about RTI/STI	Number of Women	Among those who have heard about RTI/STI, percentage who received information from.										Number of women who have heard about RTI/STI	
			Radio	Television	Newspaper/ Books/ Magazines	Slogan/ Pamphlets/ Posters/ Wall Hoardings	Doctor	Health worker	School teacher	Community Meeting	Relative/ Friends	Others		
Age group (years)														
<25	13.2	348	(76.5)	(80.4)	(68.6)	(33.3)	(17.6)	(45.1)	(7.8)	(13.7)	(43.1)	(0.0)	46	
25-29	16.8	531	68.9	74.1	59.1	26.9	19.4	43.6	6.0	24.4	52.3	2.7	89	
30-34	14.2	383	80.1	76.2	64.6	34.1	20.9	37.6	15.5	9.4	40.3	3.7	54	
35-39	14.4	299	(69.2)	(88.5)	(73.1)	(26.9)	(26.9)	(42.3)	(11.5)	(19.2)	(44.2)	(3.8)	43	
40-44	17.8	220	(87.2)	(92.3)	(66.7)	(30.8)	(35.9)	(53.8)	(12.8)	(23.1)	(48.7)	(2.6)	39	
Residence														
Rural	13.2	1,467	74.7	80.0	59.8	31.3	23.9	45.0	12.3	21.5	48.0	1.9	193	
Urban	25.0	315	77.8	83.3	81.9	30.0	21.6	36.1	7.7	9.1	49.0	3.8	79	
Education														
Non-literate	5.3	392	*	*	*	*	*	*	*	*	*	*	21	
0-9@ years	11.7	866	74.7	79.3	66.0	32.4	21.9	38.0	6.8	15.6	44.9	2.7	101	
10 and above	28.7	524	77.8	84.6	71.6	31.0	25.0	41.6	13.7	17.0	50.1	2.5	150	
Religion														
Hindu	20.1	915	74.9	84.4	71.5	32.9	19.1	34.5	10.8	12.9	48.4	1.6	183	
Muslim	25.4	138	(74.4)	(82.1)	(74.4)	(30.8)	(20.5)	(51.3)	(5.1)	(7.7)	(35.9)	(0.0)	35	
Christian	6.8	704	(87.5)	(75.0)	(43.8)	(25.0)	(37.5)	(60.4)	(12.5)	(31.3)	(45.8)	(8.3)	48	
Other	(29.2)	26	*	*	*	*	*	*	*	*	*	*	6	
Caste/tribe#														
Scheduled caste	14.1	187	(53.8)	(65.4)	(42.3)	(19.2)	(15.4)	(23.1)	(0.0)	(26.9)	(61.5)	(3.8)	26	
Scheduled tribe	4.1	517	*	*	*	*	*	*	*	*	*	*	21	
Other backward class	(14.0)	38	*	*	*	*	*	*	*	*	*	*	5	
Other	20.7	925	78.9	85.2	74.2	36.7	21.7	35.9	13.7	14.5	49.0	2.3	191	
Standard of living index														
Low	7.1	429	(64.3)	(57.1)	(32.1)	(14.3)	(21.4)	(35.7)	(7.1)	(21.4)	(46.4)	(7.1)	31	
Medium	10.6	629	67.5	71.7	52.6	41.2	20.2	45.7	14.9	22.8	52.5	2.9	67	
High	24.1	724	79.5	87.9	76.7	30.1	23.3	43.5	9.9	16.3	45.7	2.0	175	
Total	15.3	1,782	75.6	80.9	66.2	30.9	23.2	42.4	11.0	17.9	48.3	2.5	272	

Note: @ Literate women with no year of schooling are also included. #Total figure may not add to N due to do not know and missing cases. () based on less than 50 unweighted cases. * Percentage not shown – based on very few cases.

Table 8.2 SOURCE OF KNOWLEDGE ABOUT RTI/STI AMONG MEN

Percentage of husbands of eligible women who have heard about RTI/STI and among men who have heard about RTI/STI, percentage who received information from specific sources by selected background characteristics, Andaman & Nicobar Islands, 2002-04.

Background characteristic	Percentage who have heard about RTI/STI	Number of men	Among those who have heard about RTI/STI, percentage who received information from.										Number of men who have heard about RTI/STI	
			Radio	Television	Newspaper / Books/ Magazines	Slogan/ Pamphlets/ Posters/ Wall Hoardings	Doctor	Health worker	School teacher	Community Meeting	Relative/ Friends	Others		
Age group (years)														
< 25	(33.3)	31	*	*	*	*	*	*	*	*	*	*	*	15
25-34	56.3	426	79.8	85.4	40.6	45.1	16.3	48.5	7.3	13.5	39.4	2.6	240	
35-44	53.6	466	80.0	82.6	41.2	41.0	20.4	45.4	6.8	14.1	24.1	2.5	250	
45+	46.2	216	83.7	74.1	39.5	22.3	10.8	30.8	0.3	11.5	21.5	6.5	100	
Residence														
Rural	51.9	817	73.2	75.4	36.6	30.8	16.2	44.9	5.3	13.7	29.3	2.6	424	
Urban	56.0	323	95.9	95.5	49.5	58.1	20.7	43.5	6.8	11.8	32.6	4.7	181	
Education														
Non-literate	12.9	130	*	*	*	*	*	*	*	*	*	*	*	17
0-9@ years	44.5	546	77.3	78.3	27.2	29.7	9.6	44.5	3.4	10.1	29.4	4.6	243	
10 and above	74.3	464	83.3	85.0	51.3	45.8	24.0	44.3	7.6	14.7	30.1	2.5	345	
Religion														
Hindu	55.0	780	81.5	82.2	44.2	37.4	18.7	43.0	6.8	13.2	30.9	1.5	429	
Muslim	73.5	117	85.0	87.9	37.9	52.7	17.8	41.3	3.9	10.4	24.3	6.3	86	
Christian	37.2	237	68.1	71.1	24.8	33.1	11.4	54.2	2.6	15.0	33.3	8.6	88	
Caste/tribe#														
Scheduled caste	33.7	95	(80.6)	(83.9)	(41.9)	(29.0)	(29.0)	(45.2)	(9.7)	(32.3)	(35.5)	(9.7)	32	
Scheduled tribe	20.4	93	*	*	*	*	*	*	*	*	*	*	19	
Other	59.6	787	79.2	83.9	43.4	41.4	17.6	41.9	5.7	12.2	28.3	3.3	469	
Standard of living index														
Low	40.9	233	66.3	53.9	27.1	23.1	13.9	38.8	4.9	12.9	39.0	7.1	95	
Medium	37.8	355	69.6	79.1	31.1	33.9	10.2	52.8	6.2	14.9	26.2	0.9	134	
High	67.9	552	87.1	89.2	47.2	44.8	21.1	43.0	5.8	12.5	29.5	3.1	375	
Total	53.0	1,140	80.0	81.4	40.4	39.0	17.5	44.5	5.8	13.1	30.3	3.3	604	

Note: Total includes 5 cases with sikh in religion and 21 cases with other backward class in caste/tribe category on heard about of RTI/STI were not shown separately. @ Literate men with no year of schooling are also included. #Total figure may not add to N due to do not know and missing cases. () Based on less than 50 unweighted cases. * Percentage not shown – based on very few cases.

information by standard of living of households are quite visible. Only 54-66 percent of men from households with low standard of living had heard about RTI/STI from television or radio which increased to 87-89 percent for men from households with high standard of living.

8.1.1 Knowledge of Modes of Transmission of RTI/STI

Women who were aware of RTI/STI were asked about the mode of transmission. This is presented in Table 8.3.

Table 8.3 SOURCE OF KNOWLEDGE ABOUT MODE OF TRANSMISSION OF RTI/STI AMONG WOMEN						
Percentage of currently married women age 15-44 who have heard of RTI/STI by source of knowledge about mode of transmission by selected background characteristics, Andaman & Nicobar Islands, 2002-04						
Background characteristic	Percentage by knowledge of mode of transmission					Number of women who have heard of RTI/STI
	Homosexual intercourse	Heterosexual intercourse	Lack of personnel hygiene	Other	Do not know	
Age						
<25	(25.5)	(62.7)	(45.1)	(2.0)	(21.6)	46
25-29	17.8	70.5	34.7	1.5	17.1	89
30-34	27.9	62.4	49.5	4.1	21.5	54
35-39	(28.8)	(69.2)	(38.5)	(5.8)	(21.2)	43
40-44	(28.2)	(69.2)	(33.3)	(2.6)	(15.4)	39
Residence						
Rural	20.7	66.0	35.9	2.1	23.0	193
Urban	31.1	70.2	46.7	2.8	12.2	79
Education						
0-9@ years	17.2	62.1	30.1	0.6	26.6	101
10 years and above	28.9	72.9	48.1	2.8	13.2	150
Religion						
Hindu	27.0	63.3	36.5	2.2	21.9	183
Muslim	(15.4)	(76.9)	(35.9)	(0.0)	(15.4)	35
Christian	(20.8)	(72.9)	(47.9)	(6.3)	(14.6)	48
Caste/tribe#						
Scheduled caste	(11.5)	(57.7)	(42.3)	(3.8)	(30.8)	26
Other	23.5	69.4	38.1	2.2	19.0	191
Standard of living index						
Low	(17.9)	(57.1)	(28.6)	(7.1)	(39.3)	31
Medium	15.2	63.8	31.5	1.0	29.1	67
High	29.2	70.1	45.0	2.4	13.2	175
Total	23.7	67.2	39.0	2.3	19.9	272

Note: Total includes 21 cases with women education, 6 cases with other in religion and 21,5 cases with scheduled tribe and other backward class respectively in caste/tribe were not shown separately. @ Literate women with no year of schooling are also included. #Total figure may not add to N due to do not know and missing cases. () based on less than 50 unweighted cases.

Among women who reported knowledge of RTI/STI, about one-fifth of them did not know anything further about the mode of transmission of these diseases. This proportion is relatively higher among rural women, less educated women, Hindu women, women from scheduled -castes and women coming from households with low or medium standard of living. Twenty-three percent of rural women do not know about the mode of transmission of RTI/STI compared to 12 percent of urban women. Heterosexual intercourse (67 percent) and lack of personnel hygiene (39 percent) were mentioned as modes of transmission of RTI/STI by a significant proportion of the women. Around 24 percent of women reported homosexual intercourse and only 2 percent reported other modes of transmission of RTI/STI.

Table 8.4 presents the knowledge of mode of transmission of RTI/STI among men. Among men who had heard of RTI/STI, 17 percent mentioned that they did not know anything about the mode of transmission of these diseases. The percentage of men who did not know about the mode of transmission is relatively higher among rural men, less educated men, men

Table 8.4 SOURCE OF KNOWLEDGE ABOUT MODE OF TRANSMISSION OF RTI/STI AMONG MEN						
Percentage of husbands of currently married women who have heard of RTI/STI by source of knowledge about mode of transmission by selected background characteristics, Andaman & Nicobar Islands, 2002-04						
Background characteristic	Percentage by knowledge of mode of transmission					Number of men who have heard of RTI/STI
	Homosexual intercourse	Heterosexual intercourse	Lack of personnel hygiene	Other	Do not know	
Age						
25-34	19.3	77.1	42.4	0.9	12.8	240
35-44	26.3	68.5	50.8	2.2	17.3	250
45+	10.2	68.2	28.0	1.5	23.7	100
Residence						
Rural	17.5	64.2	37.6	1.6	22.0	424
Urban	28.8	87.0	55.4	1.2	5.8	181
Education						
0-9@ years	11.8	54.2	30.0	0.7	34.3	243
10 years and above	28.2	83.0	53.5	2.1	5.1	345
Religion						
Hindu	22.9	71.1	40.4	2.0	16.4	429
Muslim	15.6	89.4	57.0	0.0	8.1	86
Christian	16.4	52.2	42.1	0.6	30.1	88
Caste/tribe#						
Scheduled caste	(29.0)	(77.4)	(45.2)	(0.0)	(19.4)	32
Other	20.2	74.8	47.1	1.4	11.9	469
Standard of living index						
Low	11.4	41.0	9.3	0.3	46.5	95
Medium	11.6	58.6	43.6	0.1	23.3	134
High	26.6	83.0	51.2	2.3	7.6	375
Total	20.9	71.0	42.9	1.5	17.2	604
Note: Total includes 15 cases with <25 years in age, 17 cases with non-literate in education, 1 case with sikh in religion and 19,10 cases with scheduled tribe and other backward class respectively in caste/tribe were not shown separately. @ Literate men with no years of schooling are also included. # Total figure may not add to N due to do not know and missing cases. () based on less than 50 unweighted cases.						

from Muslim religion and men from households with a low standard of living. Among the men who knew the modes of transmission of RTI/STI, 71 percent mentioned heterosexual intercourse, around 43 percent reported lack of personal hygiene, and 21 percent mentioned homosexual intercourse, and only 2 percent reported other modes of transmission.

8.2 Prevalence of RTI/STI

In DLHS-RCH, information was collected on the common symptoms of reproductive tract infections and sexually transmitted infections from women and their husbands, and information on menstruation related problems in the three months immediately preceding the survey.

The prevalence of reproductive tract infections and sexually transmitted infections is judged by their symptoms. All the respondents were told about symptoms of RTI/STI, and were asked whether they had any of them. In case of the presence of at least one symptom, they were further asked whether they sought treatment for such problems, and if they had sought treatment, details regarding the source of treatment were also recorded. The topic of RTI/STI is quite sensitive. The culture of silence prevents people from discussing such topics in front of others. In spite of intensive training of the investigators, the respondents might have hesitated in reporting the symptoms of RTI/STI. What gets reported in the survey, though may not have given the exact prevalence, but may have given the lower limit for it.

Table 8.5 and Figure 8.2 show that about 6 percent of currently married women reported at least one reproductive health problem. The problems reported by women were 'low backache' (3 percent), 'pain in lower abdomen' and 'itching over vulva' (each 2 percent) and 'frequent/painful passage of urine and fever' (each one percent). Other symptoms of reproductive health problems reported by women were 'pain during intercourse', swelling in the groin', 'some mass coming out of vagina', 'boils/ulcers/warts around vulva', 'involuntary escape of urine while coughing or sneezing', 'swelling/lump in breast' and 'bleeding after sexual intercourse'. The prevalence of reproductive health problems is common among rural women than among urban women.

Table 8.5 SYMPTOMS OF RTI/STI AMONG WOMEN			
Percentage of currently married women age 15-44 who reported any symptoms of RTI/STI and specific symptoms during three months prior to survey, according to residence, Andaman & Nicobar Islands, 2002-04			
Symptoms	Total	Residence	
		Rural	Urban
Percentage of women reported any RTI/STI symptoms	5.8	5.4	7.5
Symptoms			
Itching over vulva	1.8	1.5	3.5
Boils/ ulcers/ warts around vulva	0.3	0.4	0.0
Pain in lower abdomen not related to menses	2.2	2.3	2.2
Low backache	3.0	2.7	4.0
Pain during sexual intercourse	0.4	0.4	0.3
Bleeding after sexual intercourse	0.1	0.1	0.0
Swelling in the groin	0.4	0.5	0.0
Frequent / painful passage of urine	1.2	1.1	1.6
Fever	0.8	0.7	1.0
Some mass coming out of vagina	0.3	0.4	0.0
Any involuntary escape of urine while coughing or sneezing	0.2	0.2	0.0
Swelling / lump in breast	0.1	0.1	0.3
Number of women	1,782	1,467	315

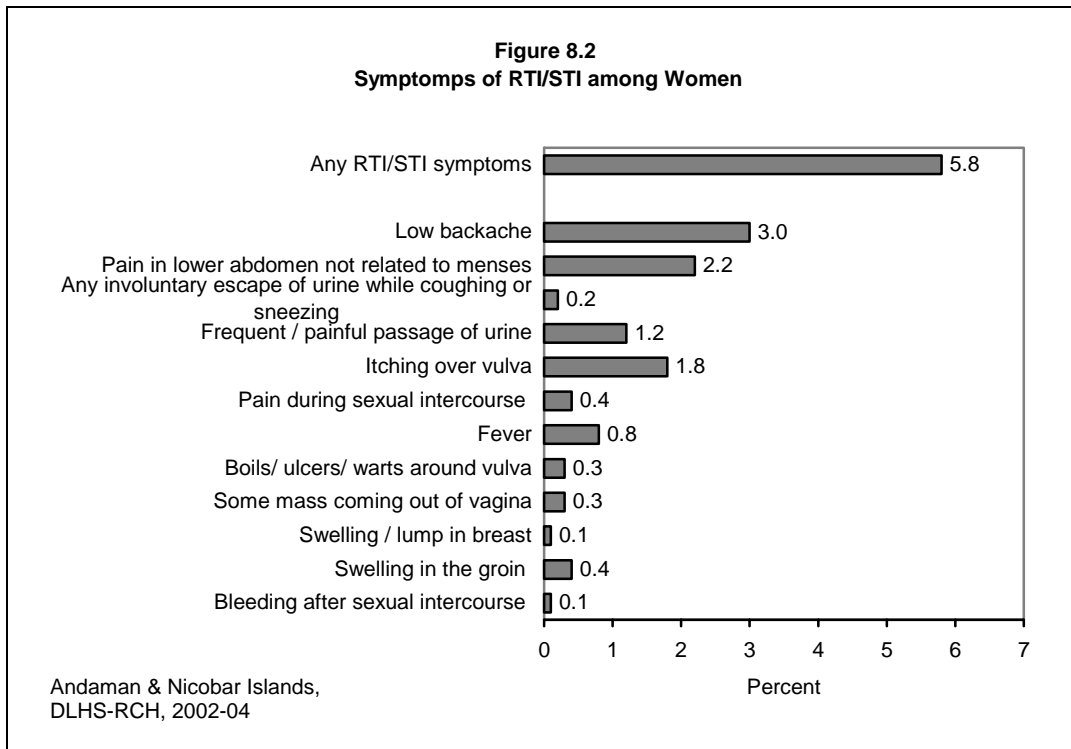


Table 8.6 and Figure 8.3 show the prevalence of reproductive health problems among husbands of currently married women. The prevalence of RTI/STI among men was judged by the reporting of symptoms. About 5 percent of men reported experiencing at least one symptom of reproductive health problem in the last three months preceding the survey. The prevalence of reproductive health problems is more among rural men (6.3 percent) than among urban men (0.7 percent). The specific problems of reproductive health experienced by men are ‘difficulty/pain while urinating or very frequent urination’ (2.4 percent), ‘itching/irritation around genital’ (2.2 percent), ‘discharge from penis’ (0.6 percent), ‘swelling of testes or in groin area’ (0.4 percent) and ‘sore / rash / redness on genitals or anal area’ (0.4 percent).

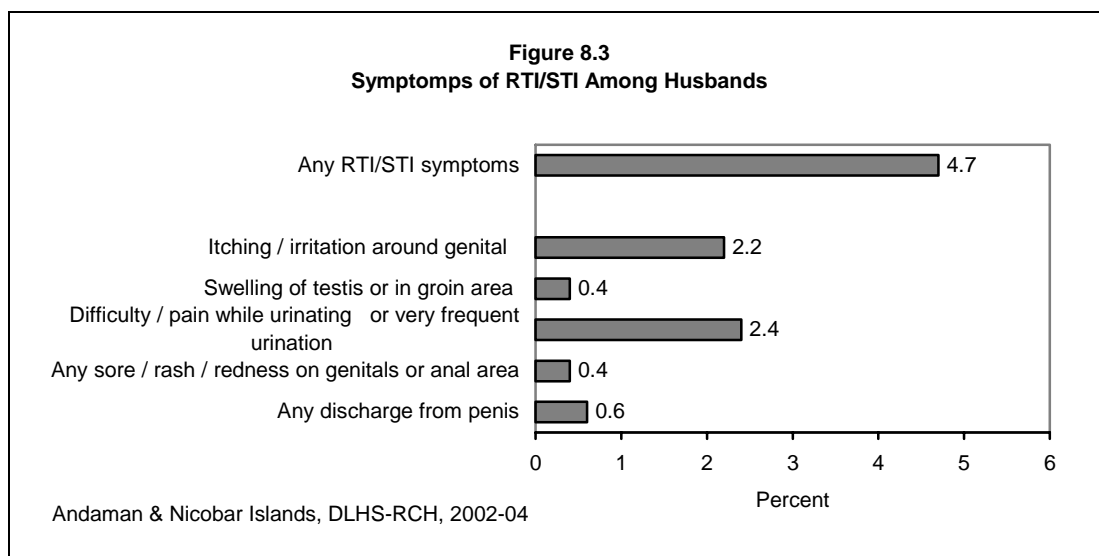


Table 8.6 SYMPTOMS OF RTI/STI AMONG MEN			
Percentage of husbands of currently married women who reported any symptoms of RTI/STI and specific symptoms during three months prior to survey and sought treatment for RTI/STI by source of treatment, according to residence, Andaman & Nicobar Islands, 2002-04			
Symptoms and treatment	Total	Residence	
		Rural	Urban
Percentage of men reported any RTI/STI symptoms	4.7	6.3	0.7
Symptoms			
Any discharge from penis	0.6	0.5	0.7
Any sore / rash / redness on genitals or anal area	0.4	0.2	0.7
Difficulty / pain while urinating or very frequent urination	2.4	3.0	0.7
Swelling of testis or in groin area	0.4	0.2	0.7
Itching / irritation around genital	2.2	3.1	0.0
Number of men	1,140	817	323
Percentage of men sought treatment for any RTI/STI	60.7	63.3	*
Number of men ¹	54	52	2
Percentage sought treatment at health facility²			
Government health facility ³	(100.0)	(100.0)	*
Sub centre	(14.3)	(14.3)	*
Chemist/ medical shop	(7.1)	(7.1)	*
Percentage obtained treatment from²			
Doctor	(85.7)	(85.7)	*
Traditional healer	(7.1)	(7.1)	*
Relative/friends	(14.3)	(14.3)	*
Home remedy	(7.1)	(7.1)	*
Other	(7.1)	(7.1)	*
Number of men ⁴	33	33	0
Note: ¹ Based on men with any symptoms of RTI/STI. ² Percentage may add to more than 100.0 due to multiple responses and based on who sought treatment. ³ Includes Government municipal hospital, dispensary, UHC/ UHP /UWFC, CHC/ rural hospital, Primary health centre, sub-centre. ⁴ Based on who sought treatment for RTI/STI. () based on less than 50 unweighted cases. * Percentage not shown – based on very few cases.			

Among men who reported reproductive health problems, 61 percent sought treatment. All of them visited a government health facility including a few visiting sub-centre. A very few also obtained treatment from a chemist or medical shop. More than four-fifths of men saw a doctor, while a few were seen by relative/friends and a traditional healer, and also used home remedies.

The DLHS-RCH also collected information from currently married women on symptoms of RTIs, that is, on abnormal vaginal discharge and texture, colour and odour of discharge in the three months immediately preceding the survey. The prevalence of reproductive health problems among currently married women is estimated from women's experiences. Table 8.7 shows the asymptotic prevalence of vaginal discharge related problems among currently married women in Andaman & Nicobar Islands during three months preceding the survey according to residence. Three percent of the women reported problems related to vaginal discharge. The prevalence of vaginal discharge problem is slightly higher among urban women (6 percent) than among rural women (2 percent).

Table 8.7 ABNORMAL VAGINAL DISCHARGE			
Percentage of currently married women age 15-44 who reported any abnormal vaginal discharge during three months prior to survey and percentage who sought treatment and source of treatment according to residence, Andaman & Nicobar Islands, 2002-04			
Symptoms and treatment	Total	Residence	
		Rural	Urban
Percentage of women reported abnormal vaginal discharge	3.0	2.4	5.8
Number of women	1,782	1,467	315
Percentage of women sought treatment for vaginal discharge	58.5	(51.2)	*
Number of women ¹	54	35	18
Percentage sought treatment at health facility ²			
Government health facility ³	(88.9)	*	*
Primary health centre	(27.8)	*	*
Private health facility ⁴	(8.3)	*	*
ISM ⁵ facility	(5.6)	*	*
Percent distribution of women who obtained treatment from ²			
Doctor	(91.7)	*	*
ANM/nurse/midwife/LHV	(8.3)	*	*
Total percent	(100.0)	*	*
Number of women	31	18	13
Note: ¹ Based on women who reported having vaginal discharge. ² Based on women who sought treatment for vaginal discharge. ³ Includes Government municipal hospital, dispensary, UHC/ UHP /UWFC, CHC/ rural hospital, Primary health centre, sub-centre and out reach/ MCP clinic in village. ⁴ Includes private hospital/ clinic, non-governmental / trust hospital/clinic, chemist/ medical shop. ⁵ Either government or private hospital/clinic of Indian system of medicine. () based on less than 50 unweighted cases. * Percentage not shown – based on very few cases.			

Among the women who had reported symptoms of vaginal discharge, 59 percent went for treatment. Around nine-tenths of women went to a government health facility, including Primary Health Centre, while less than one-tenth visited private health facilities and a few women visited ISM facility for treatment. More than nine-tenths of women in the union territory of Andaman & Nicobar Islands obtained treatment from doctors for their problems, and less than one-tenth of women were treated by ANM/Nurse/Midwife/LHV.

8.3 Menstruation Related Problems

Table 8.8 shows the percentage of women who had menstruation problems and who sought treatment during three months preceding the survey. The Table shows that 6 percent women in Andaman & Nicobar Islands had menstruation problems, and the figures are 6 percent and 5 percent in the rural and urban areas respectively.

Table 8.8 MENSTRUATION RELATED PROBLEMS

Percentage of currently married women age 15-44 who had any menstruation related problem during three months prior to survey and percentage who sought treatment and source of treatment according to residence, Andaman & Nicobar Islands, 2002-04

Symptoms and treatment	Total	Residence	
		Rural	Urban
Percentage of women with any menstruation related problem	6.1	6.3	5.2
Symptoms			
No period	5.4	6.3	0.0
Painful period	57.0	59.0	45.8
Frequent or short period	13.7	12.5	20.4
Delayed period	24.8	24.7	25.5
Prolonged bleeding	11.6	12.5	6.7
Excessive bleeding	12.7	12.7	13.0
Continuous bleeding	7.4	7.5	6.8
Scanty bleeding	16.7	14.9	27.4
Inter-menstrual bleeding	11.7	11.2	14.6
Number of women ¹	1,614	1,329	285
Percentage of women sought treatment who had any menstruation related problems	53.0	55.3	*
Number of women	99	84	15
Percentage sought treatment at health facility⁶			
Government health facility²			
Government health facility ²	98.6	(97.8)	*
Primary health centre	38.9	(39.1)	*
Sub centre	4.2	(6.5)	*
Private health facility³			
Private health facility ³	3.6	(6.5)	*
ISM⁴ facility			
ISM ⁴ facility	1.4	(2.2)	*
Percentage of women obtained treatment from⁵			
Doctor			
Doctor	99.0	(97.8)	*
ANM/nurse/midwife/LHV			
ANM/nurse/midwife/LHV	9.6	(10.9)	*
Number of women	52	46	6

Note:¹ Based on women who reported any menstruated related problems. ² Includes Government municipal hospital, dispensary, UHC/ UHP /UWFC, CHC/ rural hospital, Primary health centre, sub-centre and out reach/ MCP clinic in village. ³ Includes private hospital/ clinic, non-governmental / trust hospital/clinic, chemist/ medical shop. ⁴ Either government or private hospital/clinic of Indian system of medicine, ⁵ Multiple responses. * Percentage not shown – based on very few cases. () based on less than 50 unweighted cases.

Among the women who had reported menstrual problems, painful periods (57 percent) and delayed periods (25 percent) are the main menstrual problems prevalent in Andaman & Nicobar Islands. Scanty bleeding (17 percent), frequent or short periods (14 percent), excessive bleeding (13 percent) and prolonged bleeding and inter-menstrual bleeding (each 11 percent) are the other symptoms as reported by a sizeable proportion of women. There are minor differences in the magnitude of these symptoms among urban and rural women. Among the women who had menstrual problems, 53 percent sought treatment in the union territory. The government health facilities are the main sources of treatment for the menstrual problems. Almost all the women (99 percent) were sought treatment at a government health facility. Only 4 percent of the women traded treatment at a private facility. Most of the women went to a doctor for treatment (99 percent).

8.4 Prevalence of RTIs/STIs by Districts

Table 8.9 presents the prevalence of RTIs/STIs among currently married women and their husbands by districts. The reported symptoms of RTIs/STIs among women is lower in Nicobars (2 percent) than in Andamans (10 percent). The problems related to abnormal vaginal discharge among women are also reported less in Nicobars (one percent) than in Andamans (5 percent).

Table 8.9 REPRODUCTIVE HEALTH CARE INDICATORS BY DISTRICT					
Percentage of currently married women and their husbands who reported reproductive health problems and percentage who sought treatment for the problems by district, Andaman & Nicobar Islands, 2002-04					
District	Percentage of women			Percentage of men	
	With any symptoms of RTI/STI	Reported any abnormal vaginal discharge	Sought treatment for abnormal vaginal discharge	With any symptoms of RTI/STI	Sought treatment for RTI/STI problems
Andamans	9.7	4.7	59.0	5.2	61.0
Nicobars	1.9	1.4	(58.7)	1.2	(52.1)
Andaman & Nicobar Islands	5.8	3.0	58.5	4.7	60.7

Note: () Based on less number of cases.

In comparison to women, fewer men from both the districts of Andaman & Nicobar Islands reported symptoms of RTIs/STIs. Men from Nicobars reported lower prevalence of symptoms of RTIs/STIs (1.2 percent) than men from Andamans (5.2 percent). The data show association between the prevalence of RTIs/STIs among women and men in both the districts.

The percentage of women who have sought treatment for RTIs (abnormal vaginal discharge) is more or less the same in the two districts, while for men who have sought treatment; the figure is relatively lower in Nicobars district.

8.5 HIV/AIDS

Acquired Immune Deficiency Syndrome (AIDS) is an illness caused by the Human Immune Virus (HIV), which weakens the immune system and leads to death through secondary infection such as tuberculosis or pneumonia. The virus is generally transmitted through sexual contact, through the placenta of HIV-infected women to their children, or through contact with contaminated needle (injections) or blood. Prevalence of HIV and AIDS has been on the rise for more than a decade in India and has reached alarming proportions in recent years. To prevent HIV transmission, the government has been making various efforts.

DLHS-RCH has collected information on the general union territory of awareness of HIV/AIDS, its transmission, its prevention and common misconceptions about HIV/AIDS. All the currently married women in the age group 15-44, and their husbands were first asked if they had ever heard of an illness called HIV/AIDS. Respondents who had heard of HIV/AIDS were further asked about their source of information, mode of transmission, and correct knowledge of HIV/AIDS transfusion.

8.5.1 Knowledge of HIV/AIDS

Table 8.10 shows the percentage of women who had heard about HIV/AIDS by some selected background characteristics. Around 72 percent of currently married women in Andaman & Nicobar Islands have heard of HIV/AIDS, which is slightly higher than RCH Round – I. In Round-I, only 68 percent of currently married women were aware of HIV/AIDS.

Knowledge of HIV/AIDS is slightly lower among rural women and it is relatively much lower among non-literate women, women from scheduled tribes and women from households with a low standard of living. Around 74 percent of urban women had heard about HIV/AIDS compared to 71 percent of rural women. Knowledge of HIV/AIDS steadily increased with increase in educational level and household standard of living. Only 41 percent of non-literate women had heard of HIV/AIDS against 93 percent of women who had completed 10 or more years of schooling. Similarly, a little less than half of the women with a low standard of living (47 percent) had heard of HIV/AIDS against 87 percent of women with a high standard of living. Christian women were relatively less aware of HIV/AIDS (64 percent) compared to women from Muslim (84 percent) and Hindu (75 percent) religions. Women from scheduled tribes were less knowledgeable about HIV/AIDS (59 percent) than women belonging to 'other castes' category (79 percent) and scheduled-castes (73 percent).

The government has been using mass media, such as television, radio, and newspaper extensively to increase awareness among the general public about HIV/AIDS and its prevention. Table 8.10 also shows the percentage of currently married women who were aware of HIV/AIDS from different sources. The most prominent source of information about HIV/AIDS is television.

Eighty-five percent of women reported that television was their source of information about HIV/AIDS, followed by radio (75 percent), health workers (46 percent), relative/friends (41 percent), newspapers or books or magazines (33 percent), community meetings (31 percent) and slogans or pamphlets or posters or wall hoardings (30 percent). Twenty-one percent of the women reported that a doctor had informed them about HIV/AIDS and 12 percent of the women received information on HIV/AIDS from a school teacher.

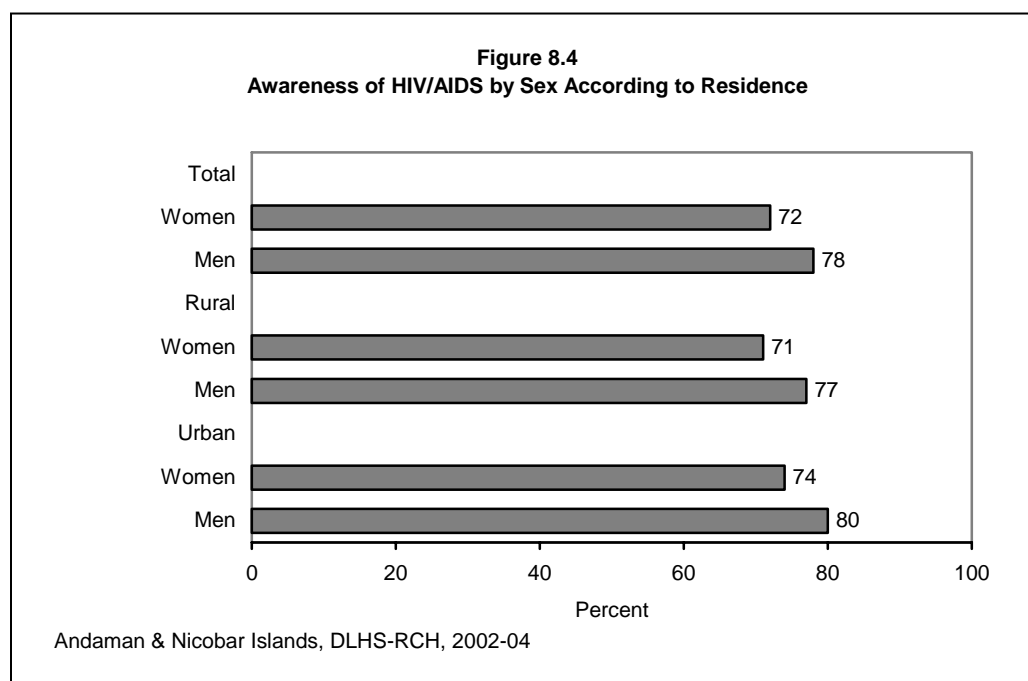


Table 8.11 shows the percentage of husbands of currently married women who had heard about HIV/AIDS. In Andaman & Nicobar Islands, the proportion of men who had heard about HIV/AIDS is relatively higher than that of women. Around 78 percent of men had heard of HIV/AIDS as compared to 72 percent of women (Figure 8.4).

Eighty percent of urban men had heard about HIV/AIDS as compared to 77 percent of rural men. Knowledge of HIV/AIDS is lower in older men. Awareness of HIV/AIDS is much lower among non-literate men, while it is relatively lower among men from scheduled tribes, men who belong to Christian religion and those from households with a low or medium standard of living. More or less a similar trend is observed in the case of women. Only 46 percent of non-literate men had heard of HIV/AIDS, and it increased up to 90 percent of men who had completed 10 or more years of schooling. It is also higher among those with high standard of living (89 percent).

Table 8.10 SOURCE OF KNOWLEDGE ABOUT HIV/AIDS AMONG WOMEN

Percentage of currently married women age 15 - 44 who have heard about HIV/AIDS and among women who have heard about HIV/AIDS, percentage who received information from specific sources by selected background characteristics, Andaman & Nicobar Islands, 2002-04.

Background characteristic	Percentage who have heard about HIV/AIDS	Number of Women	Among those who have heard about HIV/AIDS, percentage who received information from.										Number of women who have heard about HIV/AIDS
			Radio	Television	Newspaper / Books/ Magazines	Slogan/ Pamphlets/ Posters/ Wall Hoardings	Doctor	Health worker	School teacher	Community Meeting	Relative/ Friends	Others	
Age group (years)													
<25	63.2	348	74.6	86.9	36.9	35.4	17.6	45.4	18.5	28.1	39.9	4.5	220
25-29	74.8	531	75.9	86.8	37.0	32.0	25.5	47.7	9.9	34.8	41.5	5.8	398
30-34	73.8	383	72.3	77.9	29.3	25.6	16.1	46.5	11.7	30.9	42.1	5.1	283
35-39	71.6	299	74.6	84.3	29.2	26.4	20.5	48.2	8.6	28.9	43.0	4.3	214
40-44	73.6	220	76.5	91.4	30.3	26.5	23.3	37.9	16.8	32.0	37.6	5.6	162
Residence													
Rural	71.1	1,467	72.9	82.1	27.4	26.9	21.3	49.8	13.3	35.9	41.6	6.1	1,043
Urban	74.2	315	82.8	97.8	58.8	41.0	19.5	28.4	8.6	11.4	38.8	0.8	234
Education													
Non-literate	41.4	392	72.2	73.6	8.9	9.4	13.7	41.9	14.5	22.3	35.9	7.0	162
0-9@ years	72.7	866	70.6	80.4	23.8	25.9	18.7	46.0	9.0	33.2	41.1	4.5	630
10 and above	92.6	524	81.0	94.8	53.3	41.0	26.3	47.1	16.2	32.2	42.9	5.4	485
Religion													
Hindu	75.1	915	70.2	88.0	38.1	34.5	21.4	42.3	13.9	24.2	42.1	4.0	687
Muslim	83.7	138	78.0	96.3	38.2	38.5	21.0	34.8	5.5	15.9	41.6	2.7	115
Christian	64.2	704	81.4	77.1	24.5	20.2	19.8	52.8	12.2	46.2	40.2	7.7	452
Other	(87.7)	26	(72.7)	(90.9)	(40.9)	(31.8)	(31.8)	(63.6)	(13.6)	(40.9)	(36.4)	(4.5)	23
Caste/tribe#													
Scheduled caste	73.2	187	79.2	77.5	17.3	31.8	32.3	61.3	9.0	47.0	58.4	11.3	137
Scheduled tribe	58.6	517	81.3	78.8	26.3	17.9	20.9	55.5	9.9	46.7	41.2	9.4	303
Other backward class	(74.0)	38	(40.5)	(75.7)	(32.4)	(16.2)	(24.3)	(43.2)	(10.8)	(27.0)	(27.0)	(0.0)	28
Other	79.2	925	73.3	89.2	38.9	35.5	18.6	37.7	14.5	22.8	39.3	2.8	733
Standard of living index													
Low	47.2	429	67.0	54.5	17.1	15.3	11.8	47.0	8.8	34.7	43.5	7.3	202
Medium	70.8	629	67.4	82.7	23.1	25.8	21.9	51.4	15.4	35.0	43.6	6.4	445
High	86.9	724	82.4	96.4	45.4	36.7	23.2	41.7	11.5	27.8	38.6	3.5	630
Total	71.7	1,782	74.7	85.0	33.1	29.5	21.0	45.9	12.4	31.4	41.1	5.1	1,277

Note: @ Literate women with no year of schooling are also included. #Total figure may not add to N due to do not know and missing cases. () based on less than 50 unweighted cases.

* Percentage not shown – based on very few cases.

Table 8.11 SOURCE OF KNOWLEDGE ABOUT HIV/AIDS AMONG MEN

Percentage of husbands of currently married women who have heard about RTI/STI and among men who have heard about RTI/STI, percentage who received information from specific sources by selected background characteristics, Andaman & Nicobar Islands, 2002-04.

Background Characteristic	Percentage who have heard about HIV/AIDS	Number of men	Among those who have heard about HIV/AIDS, percentage who received information from.										Number of men who have heard about HIV/AIDS	
			Radio	Television	Newspaper / Books/ Magazines	Slogan/ Pamphlets/ Posters/ Wall Hoardings	Doctor	Health worker	School teacher	Community Meeting	Relative/ Friends	Others		
Age group (years)														
< 25	(63.9)	31	*	*	*	*	*	*	*	*	*	*	*	21
25-34	80.0	426	79.4	84.2	37.5	41.8	16.4	45.8	7.9	17.3	36.8	3.6	341	
35-44	81.2	466	85.8	88.8	43.3	48.1	19.9	36.0	7.1	18.3	40.6	2.9	379	
45+	67.1	216	79.4	76.5	35.9	31.7	13.1	50.7	2.4	19.3	33.6	0.3	145	
Residence														
Rural	76.7	817	78.4	78.5	34.2	35.4	17.9	47.0	6.6	20.5	39.2	2.8	627	
Urban	80.0	323	91.3	99.4	53.3	61.1	16.2	31.2	8.0	11.2	34.6	2.6	258	
Education														
Non-literate	46.4	130	54.2	56.6	12.4	8.5	9.8	24.1	6.8	16.4	48.8	2.7	60	
0-9@ years	74.4	546	78.5	79.5	25.5	40.2	12.7	40.5	3.2	17.9	39.5	2.6	406	
10 and above	90.3	464	89.8	93.6	57.5	50.5	23.0	47.0	10.8	18.0	34.7	2.9	419	
Religion														
Hindu	77.4	780	83.2	84.5	42.2	44.6	18.8	42.8	7.4	18.6	39.1	2.0	604	
Muslim	92.2	117	86.7	96.8	40.3	57.4	13.5	43.9	10.2	6.6	25.7	5.1	108	
Christian	72.0	237	75.4	77.0	30.7	28.2	14.6	40.1	3.8	21.9	40.9	3.8	171	
Caste/tribe#														
Scheduled caste	72.4	95	81.4	58.6	21.4	22.8	6.7	77.9	6.2	22.0	30.9	2.2	68	
Scheduled tribe	67.2	93	90.8	80.2	31.9	30.3	26.0	46.6	2.7	31.4	49.0	5.8	63	
Other	80.4	787	85.2	90.4	43.7	48.2	18.2	40.5	7.9	16.7	34.2	1.6	633	
Standard of living index														
Low	69.9	233	63.2	48.8	19.9	31.9	9.1	48.6	3.8	15.4	45.6	0.5	163	
Medium	64.8	355	81.1	83.8	36.0	33.2	17.0	36.1	7.2	21.2	40.0	3.6	230	
High	89.2	552	88.9	96.8	48.0	51.1	20.3	43.4	8.1	17.1	34.3	3.0	493	
Total	77.7	1,140	82.2	84.6	39.7	42.9	17.4	42.4	7.0	17.8	37.9	2.7	885	

Note: Total includes 5 cases with sikh in religion and 21 cases with other backward class in caste/tribe category on heard about of HIV/AIDS were not shown separately. @ Literate men with no year of schooling are also included. # Total figure may not add to N due to don't and missing cases. () based on less than 50 unweighted cases. * Percentage not shown – based on very few cases.

Table 8.11 also shows the percentage of husbands of currently married women who were aware of HIV/AIDS by different sources. As reported by the men of Andaman & Nicobar Islands, the most prominent source of information of HIV/AIDS was television (85 percent) followed by radio (82 percent). Other important sources of knowledge of HIV/AIDS are the slogans or pamphlets or posters or wall hoardings (43 percent), health worker (42 percent), newspapers or books or magazines (39 percent) and relatives or friends (38 percent). Only 17 percent of men reported that a doctor had informed them about HIV/AIDS.

About 18 percent reported that they were informed through community meetings and 7 percent received such information from a school teacher. Comparatively, a higher proportion of rural men received information about HIV/AIDS from health worker, community meeting and relatives or friends than urban men. The information on awareness of HIV/AIDS through mass media, such as television, radio, slogans or pamphlets or posters or wall hoardings and newspapers or books or magazines, was received more by urban men, men with at least 10 years of schooling, and men from households with a high standard of living. On the other hand, relatives or friends were the main source of information for rural men, non-literate men, men from scheduled tribes and men from households with a low standard of living.

8.5.2 Knowledge of Modes of Transmission about HIV/AIDS

Women who were aware of HIV/AIDS were asked about the modes of transmission and the details are presented in Table 8.12. Among women who reported awareness of HIV/AIDS, about 16 percent did not know about the mode of transmission. Around 17 percent of the rural women do not know about the mode of transmission of HIV/AIDS compared to 12 percent of urban women. This proportion is relatively higher among non-literate (25 percent) and less educated (24 percent) women and women from households with a low (32 percent) and medium (17 percent) standard of living.

Among women who reported different ways of transmission of HIV/AIDS, a large proportion (72 percent) mentioned heterosexual intercourse as a mode of transmission. All the socio-economic groups reported that heterosexual intercourse was the main mode of transmission of HIV/AIDS. Other modes reported by women were transmission through needle or blade or skin puncture (57 percent), transfusion of infected blood (51 percent) and mother to child, if pregnancy occurs during a stage of HIV (27 percent), while 28 percent of the women mentioned that homosexual intercourse could also be a mode of transmission. About 5 percent stated that there were other ways of transmission of HIV/AIDS.

Table 8.12 SOURCE OF KNOWLEDGE ABOUT MODE OF TRANSMISSION OF HIV/AIDS AMONG WOMEN

Percentage currently married women age 15-44 who have heard of HIV/AIDS by source of knowledge about mode of transmission by selected background characteristics, Andaman & Nicobar Islands, 2002-04

Background characteristic	Percentage by knowledge of mode of transmission						Do not know	Number of women who have heard of HIV/AIDS
	Homo sexual intercourse	Hetero sexual intercourse	Needles/ blade/ skin puncture	Mother to child	Transfusion of infected blood	Other		
Age								
<25	32.2	70.6	57.1	26.6	50.7	4.3	16.7	220
25-29	29.8	77.9	65.7	29.7	55.4	4.5	9.8	398
30-34	25.1	67.8	47.1	24.6	48.3	5.7	19.8	283
35-39	27.5	69.3	55.8	23.2	47.7	3.9	20.0	214
40-44	25.7	67.3	57.2	28.5	48.9	4.2	17.5	162
Residence								
Rural	26.6	71.7	57.1	27.3	50.8	5.1	16.7	1,043
Urban	35.6	71.3	58.7	24.3	51.5	2.4	12.4	234
Education								
Non-literate	15.2	67.4	40.6	14.0	24.3	4.0	25.1	162
0-9@ years	24.1	64.7	46.0	18.9	41.0	3.8	23.6	630
10 years and above	38.0	82.1	77.8	41.2	72.6	5.8	2.8	485
Religion								
Hindu	28.5	70.1	55.8	25.8	50.2	4.3	15.7	687
Muslim	22.7	71.4	63.2	29.9	48.1	4.8	14.0	115
Christian	29.7	73.0	58.2	27.2	52.3	5.2	17.5	452
Caste/tribe#								
Scheduled caste	16.1	78.0	57.4	32.9	59.2	4.4	10.7	137
Scheduled tribe	32.5	72.4	57.9	26.7	53.2	6.4	18.3	303
Other backward class	(5.4)	(83.8)	(62.2)	(21.6)	(56.8)	(2.7)	(5.4)	28
Other	28.6	70.3	56.7	26.0	48.4	4.2	16.0	733
Standard of living index								
Low	21.7	54.7	41.0	13.3	36.9	3.2	32.1	202
Medium	25.4	72.5	52.9	25.2	47.4	5.8	17.3	445
High	32.4	76.4	65.8	32.2	57.9	4.3	9.7	630
Total	28.3	71.6	57.4	26.8	50.9	4.6	15.9	1,277

Note: Total includes 23 cases with other in religion were not shown separately. @ Literate women with no year of schooling are also included. #Total figure may not add to N due to do not know and missing cases. () based on less than 50 unweighted cases.

Table 8.13 presents the knowledge about mode of transmission of HIV/AIDS among men. Around 13 percent of the men who had heard about HIV/AIDS mentioned that they do not know the mode of transmission. The percentage of men not knowing the mode of transmission is higher among older men, rural men, non-literate and less educated men, men from scheduled-castes, and men from households with a low or medium standard of living. Among men who reported ways of transmission of HIV/AIDS, about 75 percent of them mentioned heterosexual intercourse as a mode of transmission. All the groups reported that heterosexual intercourse was the main mode of transmission of HIV/AIDS. Other modes reported by men are transmission through transfusion of infected blood (57 percent), needle or blade or skin puncture (51 percent), and mother to child, if pregnancy occurs during a stage of HIV (25 percent), while 31 percent of men mentioned that homosexual intercourse could also be a mode of transmission of HIV/AIDS. Two percent stated that there were other ways of transmission of HIV/AIDS.

Table 8.13 SOURCE OF KNOWLEDGE ABOUT MODE OF TRANSMISSION OF HIV/AIDS AMONG MEN

Percentage of husbands of currently married women who have heard of HIV/AIDS by source of knowledge about mode of transmission by selected background characteristics, Andaman & Nicobar Islands, 2002-04

Background characteristic	Percentage by knowledge of mode of transmission						Do not know	Number of men who have heard of HIV/AIDS
	Homosexual intercourse	Heterosexual intercourse	Needles/ blade/ skin puncture	Mother to child	Transfusion of infected blood	Other		
Age								
25-34	31.8	77.7	51.4	24.7	58.8	2.4	9.8	341
35-44	32.3	74.6	49.6	28.6	60.4	2.1	12.6	379
45+	25.4	67.2	54.3	18.5	48.4	0.3	23.9	145
Residence								
Rural	25.5	68.8	47.8	20.8	49.9	1.6	18.5	627
Urban	44.7	88.6	58.9	35.8	75.8	2.7	0.7	258
Education								
Non-literate	19.5	45.6	17.4	5.4	22.2	2.3	42.5	60
0-9@ years	27.3	65.8	41.9	13.7	49.5	1.0	19.5	406
10 years and above	36.4	87.2	64.8	39.2	70.2	2.7	3.2	419
Religion								
Hindu	31.9	74.3	54.5	25.9	59.5	1.8	11.7	604
Muslim	29.0	87.5	46.8	29.8	53.4	0.1	8.9	108
Christian	29.6	67.0	41.2	19.9	52.0	3.1	22.3	171
Caste/tribe#								
Scheduled caste	27.5	69.0	33.8	22.4	51.1	2.0	28.1	68
Scheduled tribe	28.1	72.8	59.2	23.2	56.3	5.2	13.8	63
Other	29.9	78.0	53.6	26.5	60.0	1.7	8.9	633
Standard of living index								
Low	27.5	51.1	24.7	7.4	37.6	0.4	29.8	163
Medium	23.0	68.9	52.7	24.8	48.8	2.0	18.7	230
High	36.1	84.9	59.0	31.3	68.0	2.3	5.4	493
Total	31.1	74.5	51.1	25.2	57.4	1.9	13.3	885

Note: Total includes 21 cases with <25 in age, 2 cases with sikh in religion and 18 cases with other backward class in caste/tribe were not shown separately. @ Literate men with no year of schooling are also included. #Total figure may not add to N due to do not know and missing cases.

8.5.3 How to avoid HIV/AIDS

All the respondents, male and female, were asked about how to prevent HIV/AIDS. The percentage of women who said that HIV/AIDS could be avoided by various ways has been presented in Table 8.14 by some selected background characteristics.

Among women who reported about awareness of HIV/AIDS, about 17 percent did not know how to avoid becoming infected by HIV/AIDS. This percentage is relatively higher among rural women than among urban women. The percentage of women who did not know of any ways to avoid infection decreases with increasing levels of education and household standard of living. Around 28 percent of non-literate women reported that they did not know of any ways to avoid infection as compared to 5 percent of women who had completed 10 or more years of schooling. Similarly, about 31 percent of women with low a standard of living stated that they did not know of any ways to avoid infection as compared to 11 percent of women with a high standard of living. The percentage of women who did not know the ways to avoid infection is also higher among scheduled-tribe women.

Table 8.14 KNOWLEDGE ABOUT AVOIDANCE OF HIV/AIDS AMONG WOMEN

Percentage of currently married women age 15-44 who have heard about HIV/AIDS and who reported that HIV/AIDS can be avoided in specific ways by selected background characteristics, Andaman & Nicobar Islands, 2002-04

Background characteristic	Percentage reported HIV/AIDS can be avoided by:							Number of women
	Sex With Only one partner	Using condoms correctly during each sexual intercourse	Checking blood prior to transfusion	Sterilizing needles and syringes for injection	Avoiding pregnancy when having HIV/AIDS	Other	Do not know to avoid HIV/AIDS	
Age								
<25	75.7	56.2	44.4	49.6	18.5	5.1	19.1	220
25-29	81.0	59.3	55.6	52.1	24.6	6.7	10.2	398
30-34	73.0	44.7	48.9	42.6	17.9	3.3	19.0	283
35-39	71.0	46.5	45.5	44.2	18.2	4.4	22.8	214
40-44	75.6	42.6	47.5	47.0	26.0	5.0	17.5	162
Residence								
Rural	74.0	50.4	49.5	47.6	21.0	5.7	18.0	1,043
Urban	84.4	55.3	49.5	47.5	21.9	2.2	11.1	234
Education								
Non-literate	62.8	27.1	22.2	32.8	11.0	6.3	28.2	162
0-9@ years	70.8	43.7	40.5	37.2	16.4	4.1	22.6	630
10 years and above	87.0	69.1	70.2	66.1	30.8	5.9	5.3	485
Religion								
Hindu	75.7	48.6	47.2	45.3	20.8	5.0	17.4	687
Muslim	79.5	58.3	48.4	52.2	27.5	1.8	15.3	115
Christian	75.1	53.4	52.8	49.7	20.1	6.2	16.4	452
Caste/tribe#								
Scheduled caste	76.7	56.5	51.0	51.0	25.8	10.9	10.6	137
Scheduled tribe	71.5	53.3	54.5	52.6	19.0	6.7	19.5	303
Other backward class	(89.2)	(73.0)	(48.6)	(59.5)	(13.5)	(5.4)	(8.1)	28
Other	77.5	48.6	47.3	43.5	21.0	2.9	16.5	733
Standard of living index								
Low	61.0	31.2	36.4	33.5	9.8	6.4	30.7	202
Medium	74.1	49.6	45.8	46.4	20.5	5.9	18.1	445
High	82.1	58.9	56.2	53.0	25.3	4.1	11.3	630
Total	75.9	51.3	49.5	47.6	21.2	5.1	16.7	1,277

Note: Total includes 23 cases with other in religion were not shown separately. @ Literate women with no year of schooling are also included. #Total figure may not add to N due to do not know and missing cases. () based on less than 50 unweighted cases.

Among women who mentioned ways to avoid HIV/AIDS, a higher proportion of women (76 percent) said that “sex with only one partner” is a way to avoid it. Other ways to prevent HIV/AIDS mentioned by women were ‘using a condom correctly during each sexual intercourse’ (51 percent), ‘checking blood prior to transfusion’ (50 percent) and ‘sterilizing needles and syringes before injecting’ (48 percent), while 21 percent of the women reported that the pregnancy should be avoided if couples were infected by HIV/AIDS. All the specific ways to avoid becoming infected by HIV/AIDS reported by women are proportionally higher among women with a high level of education and those from the households with a high standard of living.

Table 8.15 shows the percentage of men who reported that HIV/AIDS could be avoided by some selected background characteristics. Among men who are aware of HIV/AIDS, about 13 percent did not know of any method to avoid infection, compared to 17 percent women in the union territory.

Background characteristic	Percentage reported HIV/AIDS can be avoided by:							Number of men
	Sex with only one partner	Using condoms correctly during each sexual intercourse	Checking blood prior to transfusion	Sterilizing needles and syringes for injection	Avoiding pregnancy when having HIV/AIDS	Other	Do not know to avoid HIV/AIDS	
Age								
25-34	84.8	57.2	54.7	49.2	19.8	1.5	10.0	341
35-44	79.2	54.9	57.3	50.4	22.8	2.5	12.0	379
45+	70.6	39.7	43.8	42.4	13.9	4.3	24.7	145
Residence								
Rural	76.8	44.7	44.7	44.7	16.1	2.0	18.1	627
Urban	88.2	75.0	76.7	58.3	29.5	3.3	1.8	258
Education								
Non-literate	53.3	26.5	21.5	22.9	5.6	2.7	42.2	60
0-9@ years	70.5	46.3	42.5	36.9	11.9	1.8	20.3	406
10 years and above	93.3	64.4	70.0	63.8	29.9	2.9	2.5	419
Religion								
Hindu	82.5	52.5	54.3	50.1	20.6	1.2	12.1	604
Muslim	85.2	63.7	69.0	55.1	21.4	3.4	4.6	108
Christian	67.9	50.6	43.2	39.2	16.7	5.9	23.6	171
Caste/tribe#								
Scheduled caste	76.6	41.9	34.7	36.5	14.8	3.4	18.8	68
Scheduled tribe	68.6	60.5	56.6	56.7	15.4	4.6	17.7	63
Other	83.4	56.5	59.3	50.7	20.9	2.0	9.6	633
Standard of living index								
Low	69.7	26.5	25.6	26.5	8.4	1.6	28.8	163
Medium	68.6	51.9	46.2	44.5	17.6	1.9	21.6	230
High	88.9	63.2	67.1	58.0	25.0	2.9	4.4	493
Total	80.1	53.5	54.0	48.7	20.0	2.4	13.4	885

Note: Total includes 21 cases with <25 years in age, 2 cases with sikh in religion and 18 cases with other backward class in caste/tribe were not shown separately. @ Literate men with no year of schooling are also included. #Total figure may not add to N due to do not know and missing cases.

In Andaman & Nicobar Islands, a majority of the women (76 percent) reported that 'sex with only one partner' is a way to avoid HIV/AIDS, a still higher proportion of men (80 percent) also reported the same, and this was the most commonly reported way to avoid HIV/AIDS in all the socio-economic groups. Other ways to prevent HIV/AIDS mentioned by men are 'checking blood prior to transfusion' and 'using a condom correctly during each sexual intercourse' (each 54 percent) and 'sterilizing needles and syringes before injecting' (49 percent), while 20 percent of the men reported that the pregnancy should be avoided if couples were infected by HIV/AIDS.

All the specific ways to avoid becoming infected by HIV/AIDS reported by men are proportionally higher in urban areas than in rural areas, and among Muslim men, among men with a high level of education and among those from the households with a high standard of living. Scheduled tribe men were more likely to report that HIV/AIDS can be avoided by using a condom correctly during each sexual intercourse.

8.5.4 Misconceptions about HIV/AIDS

People generally have misconceptions about the ways of transmission of HIV/AIDS, such as 'shaking hands with a person having AIDS', hugging or kissing them, sharing their clothes or sharing eating utensils, stepping on their urine/stool, through insect bites, for example, being bitten by mosquitoes, fleas and bedbugs. All these questions were asked to the respondents who had heard of HIV/AIDS.

Table 8.16 shows the percentage of women with misconceptions about spreading HIV/AIDS through specific ways by selected background characteristics.

Table 8.16 MISCONCEPTION ABOUT TRANSMISSION OF HIV/AIDS AMONG WOMEN								
Percentage of currently married women age 15-44 who have heard about HIV/AIDS and having misconceptions about the transmission of HIV/AIDS by selected background characteristics, Andaman & Nicobar Islands, 2002-04								
Background characteristic	Percentage having misconception about the transmission of HIV/AIDS							Number of women
	Shaking hands	Hugging	Kissing	Sharing clothes	Sharing eating utensils	Stepping on Urine / stool	Mosquito, flea, or bedbugs biting	
Residence								
Rural	3.4	4.1	6.4	5.0	5.2	8.3	10.7	1,043
Urban	4.1	3.9	8.2	4.9	6.0	5.1	6.4	234
Education								
Non-literate	2.1	3.4	4.9	2.3	3.9	7.1	12.5	162
0-9@ years	4.1	5.2	8.3	6.8	6.4	8.3	10.1	630
10 years and above	3.1	2.8	5.3	3.5	4.4	7.1	8.9	485
Religion								
Hindu	4.8	5.1	8.4	5.8	7.1	7.3	9.7	687
Muslim	1.0	3.2	7.3	5.1	7.0	9.8	12.7	115
Christian	2.2	2.9	4.0	3.9	2.4	7.8	9.7	452
Caste/tribe#								
Scheduled caste	0.3	0.0	2.7	1.4	2.1	8.7	5.8	137
Scheduled tribe	1.7	1.3	2.2	1.8	1.9	5.4	8.5	303
Other backward class	(5.4)	(2.7)	(13.5)	(10.8)	(13.5)	(8.1)	(2.7)	28
Other	4.9	6.0	8.8	6.2	6.7	8.6	10.6	733
Standard of living index								
Low	6.9	5.2	8.6	8.1	7.0	11.3	13.2	202
Medium	2.3	4.6	6.1	5.0	4.5	7.5	10.5	445
High	3.2	3.3	6.6	3.9	5.4	6.6	8.4	630
Total	3.5	4.1	6.7	5.0	5.3	7.7	9.9	1,277

Note: Total includes 23 cases with other in religion were not shown separately. @ Literate women with no year of schooling are also included. #Total figure may not add to N due to do not know and missing cases. () based on less than 50 unweighted cases.

Being bitten by mosquitoes, fleas or bedbugs is reported by around 10 percent of women as a way of getting HIV/AIDS infection and this percentage is relatively higher among rural areas (11 percent) than in urban areas (6 percent). A slightly lower proportion of women belonging to scheduled castes or tribes, literate women who have completed 10 or more years of schooling and women from households with a high standard of living mentioned this method of transmission. Other misconceptions about the spreading of HIV/AIDS were 'stepping on urine/stool' (8 percent), 'kissing' (7 percent), 'sharing eating utensils' and 'sharing clothes' (each 5 percent) and 'hugging' and 'shaking hands' (each 4 percent). The women belonging to different socio-economic groups mentioned these misconceptions in varying degree.

Table 8.17 presents the percentage of men with misconceptions about the spreading of HIV/AIDS through specific ways by selected background characteristics.

Table 8.17 MISCONCEPTION ABOUT TRANSMISSION OF HIV/AIDS AMONG MEN								
Percentage of husbands of currently married women who have heard about HIV/AIDS and having misconceptions about the transmission of HIV/AIDS by selected background characteristics, Andaman & Nicobar Islands, 2002-04								
Background characteristic	Percentage having misconception about the transmission of HIV/AIDS							Number of men
	Shaking hands	Hugging	Kissing	Sharing clothes	Sharing eating utensils	Stepping on Urine / stool	Mosquito, flea, or bedbugs biting	
Residence								
Rural	4.0	5.0	15.5	3.6	3.8	5.0	6.7	627
Urban	1.5	1.5	31.2	2.8	0.6	0.6	3.6	258
Education								
Non-literate	6.0	5.9	16.8	5.9	5.9	4.8	15.2	60
0-9@ years	3.7	5.6	22.7	5.1	3.4	5.0	6.0	406
10 years and above	2.4	2.2	17.9	1.3	1.9	2.3	4.3	419
Religion								
Hindu	3.5	4.6	21.7	4.2	3.6	4.1	7.2	604
Muslim	2.9	4.2	33.1	3.1	1.4	4.9	2.1	108
Christian	2.3	1.8	6.3	0.6	1.1	1.5	3.5	171
Caste/tribe#								
Scheduled caste	4.1	3.6	24.8	0.4	0.4	0.8	4.7	68
Scheduled tribe	2.4	1.1	5.2	1.2	2.2	3.3	5.3	63
Other	3.2	4.4	22.4	4.3	3.0	3.8	4.8	633
Standard of living index								
Low	6.4	9.4	29.5	7.3	6.5	6.5	11.2	163
Medium	1.2	3.0	11.0	3.2	1.9	3.1	5.2	230
High	3.1	2.7	21.1	2.1	2.1	3.1	4.3	493
Total	3.2	4.0	20.0	3.4	2.9	3.7	5.8	885

Note: Total includes 2 cases with sikh in religion and 18 cases with other backward class in caste/tribe were not shown separately. @ Literate men with no year of schooling are also included. #Total figure may not add to N due to do not know and missing cases.

Unlike the women, a relatively higher proportion of the men in all the socio-economic groups reported that HIV/AIDS is transmitted through kissing of the infected person. Twenty percent of the men in Andaman & Nicobar Islands felt so. The percentage who reported that HIV/AIDS could be transmitted through kissing was relatively higher among urban men (31 percent) than among rural men (16 percent). A lower proportion of Christian men and men from scheduled tribes are of the impression that HIV/AIDS will not spread when kissing an infected person. Other misconceptions about the spread of HIV/AIDS are ‘mosquito, flea or bedbugs biting’ (6 percent), ‘hugging’ and ‘stepping on urine/stool’ (each 4 percent) and ‘sharing clothes’, ‘shaking hands’ and ‘sharing eating utensils’ (each 3 percent). All these misconceptions reported by men are slightly lower than those reported by women. The men belonging to different socio-economic groups also mentioned these misconception in varying degree.

8.5.5 Knowledge of Curability of HIV/AIDS

Table 8.18 shows the percentage distribution of currently married women and their husbands who have heard about HIV/AIDS by knowledge of curability of the same, according to some selected background characteristics.

Table 8.18 KNOWLEDGE OF CURABILITY ABOUT HIV/AIDS								
Percentage distribution of currently married women and their husband who have heard about HIV/AIDS by knowledge of curability about HIV/AIDS, according to some selected background characteristics, Andaman & Nicobar Islands, 2002-04								
Background characteristic	Percent distribution of women			Number of women	Percent distribution of men			Number of men
	Yes	No	Do not know		Yes	No	Do not know	
Residence								
Rural	21.5	56.5	22.0	1,043	8.2	71.4	20.4	627
Urban	12.1	74.8	13.1	234	7.8	85.4	6.8	258
Education								
Non-literate	13.3	43.7	43.0	162	13.3	44.6	42.1	60
0-9@ years	19.9	56.6	23.6	630	7.6	66.6	25.8	406
10 years and above	21.9	69.4	8.6	485	7.9	88.6	3.5	419
Religion								
Hindu	19.5	62.0	18.5	687	7.7	76.7	15.6	604
Muslim	22.8	61.6	15.6	115	8.8	82.4	8.8	108
Christian	19.4	55.7	24.9	452	9.1	66.9	24.0	171
Caste/tribe#								
Scheduled caste	30.2	51.4	18.4	137	10.0	66.7	23.3	68
Scheduled tribe	18.2	52.5	29.3	303	15.2	61.1	23.8	63
Other backward class	(18.9)	(59.5)	(21.6)	28	*	*	*	18
Other	18.6	66.1	15.3	733	7.7	82.0	10.2	633
Standard of living index								
Low	20.1	56.3	23.6	202	8.9	58.3	32.8	163
Medium	22.3	50.7	27.0	445	5.5	69.9	24.6	230
High	18.0	67.4	14.7	630	9.0	83.8	7.2	493
Total	19.8	59.8	20.4	1,277	8.1	75.5	16.4	885

Note: Total includes 23 cases with other and 2 cases with sikh in religion category were not shown separately of women and men respectively. @ Literate persons with no year of schooling are also included. #Total figure may not add to N due to do not know and missing cases. () based on less than 50 unweighted cases. * Percentage not shown – based on very few cases.

Around 20 percent women and 8 percent men have the notion that HIV/AIDS is curable, whereas 60 percent women and 76 percent men replied that the disease is not curable. Around 20 percent women and 16 percent men do not have any idea regarding the curability of the disease. It can be noted from the figures that both men and women of urban area, belonging 'other castes' category, having high level of education and from households of high standard of living are having better knowledge as far as curability of HIV/AIDS is concerned.

8.6 Awareness of RTI/STI and HIV/AIDS by Districts

Table 8.19 shows the percentage distribution of currently married women and their husbands who are aware of RTI/STI and HIV/AIDS by districts.

Table 8.19 AWARENESS OF RTI/STI AND HIV/AIDS BY DISTRICT				
Percentage of currently married women and their husbands aware of RTI/STI and HIV/AIDS by district, Andaman & Nicobar Islands, 2002-04				
District	Percentage of women		Percentage of men	
	Aware of RTI/STI	Aware of HIV/AIDS	Aware of RTI/STI	Aware of HIV/AIDS
Andamans	23.6	76.3	57.7	78.7
Nicobars	7.0	66.6	16.8	69.9
Andaman & Nicobar Islands	15.3	71.7	53.0	77.7

According to DLHS-RCH, around 15 percent and 72 percent respectively of women were aware of RTI/STI and HIV/AIDS and the corresponding figures for husbands of eligible women are 53 and 78 percent. The awareness of RTI/STI and HIV/AIDS among men is higher than that among women by 38 and 6 percentage points respectively.

In both the districts of Andaman & Nicobar Islands men are more aware of RTI/STI and HIV/AIDS than women. A relatively higher level of awareness about RTI/STI among women was reported in Andamans district (24 percent) than in Nicobars district (7 percent). Among men also a higher level of awareness of RTI/STI was reported in Andamans (58 percent) than in Nicobars (17 percent).

The proportions of currently married women aged 15-44 and their husbands who are aware of HIV/AIDS in the districts of the union territory of Andaman & Nicobar Islands are also presented in Table 8.19. Among women, the awareness about HIV/AIDS is relatively higher in Andamans district (76 percent) than in Nicobars district (67 percent). A relatively higher level of awareness of HIV/AIDS among men was also reported in Andamans district (79 percent) than in Nicobars district (70 percent).

Sampling errors, Andaman and Nicobar Island, 2002-04							
District	Estimate (R)	Sampling error (SE)	Number of cases		Relative Error (%)	95% Conf. Interval	
			Unweighted	Weighted		R-1.96 SE	R+1.96 SE
Contraceptive Prevalence Rate (Currently Married Women age 15-44)							
Andamans	0.601	0.021	894	894	3.4	0.561	0.641
Nicobars	0.568	0.019	873	873	3.4	0.530	0.605

Sampling errors, Andaman and Nicobar Island, 2002-04							
District	Estimate (R)	Sampling error (SE)	Number of cases		Relative Error (%)	95% Conf. Interval	
			Unweighted	Weighted		R-1.96 SE	R+1.96 SE
Unmet Need (Currently Married Women age 15-44)							
Andamans	0.257	0.019	894	894	7.3	0.220	0.293
Nicobars	0.260	0.017	873	873	6.6	0.227	0.294

Sampling errors, Andaman and Nicobar Island, 2002-04							
District	Estimate (R)	Sampling error (SE)	Number of cases		Relative Error (%)	95% Conf. Interval	
			Unweighted	Weighted		R-1.96 SE	R+1.96 SE
Received Any Antenatal Check ups (last live/still births of past 3 years)							
Andamans	0.976	0.008	356	360	0.8	0.961	0.991
Nicobars	0.965	0.011	335	333	1.2	0.943	0.987

Sampling errors, Andaman and Nicobar Island, 2002-04							
District	Estimate (R)	Sampling error (SE)	Number of cases		Relative Error (%)	95% Conf. Interval	
			Unweighted	Weighted		R-1.96 SE	R+1.96 SE
Received 3+ Antenatal Check ups (last live/still births of past 3 years)							
Andamans	0.967	0.009	356	359	0.9	0.949	0.984
Nicobars	0.909	0.018	335	333	2.0	0.874	0.945

Sampling errors, Andaman and Nicobar Island, 2002-04							
District	Estimate (R)	Sampling error (SE)	Number of cases		Relative Error (%)	95% Conf. Interval	
			Unweighted	Weighted		R-1.96 SE	R+1.96 SE
Institutional Delivery (last live/still births of past 3 years)							
Andamans	0.786	0.031	356	359	4.0	0.724	0.847
Nicobars	0.718	0.029	335	333	4.0	0.661	0.775

Sampling errors, Andaman and Nicobar Island, 2002-04							
District	Estimate (R)	Sampling error (SE)	Number of cases		Relative Error (%)	95% Conf. Interval	
			Unweighted	Weighted		R-1.96 SE	R+1.96 SE
Safe Delivery (last live/still births of past 3 years)							
Andamans	0.805	0.031	356	359	3.8	0.744	0.865
Nicobars	0.749	0.028	335	333	3.8	0.693	0.804

Sampling errors, Andaman and Nicobar Island, 2002-04							
District	Estimate (R)	Sampling error (SE)	Number of cases		Relative Error (%)	95% Conf. Interval	
			Unweighted	Weighted		R-1.96 SE	R+1.96 SE
Received BCG Vaccination (last and last but one living children, age 12-23 months)							
Andamans	0.993	0.007	102	59	0.7	0.980	1.007
Nicobars	0.968	0.023	105	106	2.3	0.923	1.013

Sampling errors, Andaman and Nicobar Island, 2002-04							
District	Estimate (R)	Sampling error (SE)	Number of cases		Relative Error (%)	95% Conf. Interval	
			Unweighted	Weighted		R-1.96 SE	R+1.96 SE
Received Measles Vaccination (last and last but one living children, age 12-23 months)							
Andamans	0.854	0.035	102	59	4.1	0.785	0.922
Nicobars	0.855	0.042	105	107	4.9	0.773	0.937

Sampling errors, Andaman and Nicobar Island, 2002-04							
District	Estimate (R)	Sampling error (SE)	Number of cases		Relative Error (%)	95% Conf. Interval	
			Unweighted	Weighted		R-1.96 SE	R+1.96 SE
Birth order 3+ (births in last three years)							
Andamans	0.155	0.024	316	308	15.1	0.109	0.202
Nicobars	0.266	0.029	303	304	11.0	0.208	0.323

Sampling errors, Andaman and Nicobar Islands, 2002-04								
Variables	Estimate (R)	Sampling error (SE)	Number of cases		Design Effect	Relative Error (%)	95% Conf. Interval	
			Unweighted	Weighted			R-1.96 SE	R+1.96 SE
Contraceptive Prevalence Rate (Currently Married Women age 15-44)								
Total	0.592	0.020	1,767	1,767	2.926	3.4	0.553	0.631
Rural	0.585	0.024	1,452	1,452	3.321	4.0	0.539	0.631
Urban	0.625	0.027	315	315	1.010	4.4	0.572	0.679
Unmet Need (Currently Married Women age 15-44)								
Total	0.262	0.018	1,767	1,767	3.112	7.0	0.226	0.298
Rural	0.269	0.022	1,452	1,452	3.516	8.1	0.226	0.312
Urban	0.231	0.024	315	315	1.013	10.4	0.184	0.278
Received Any Antenatal Check up (last live/still births of past 3 years)								
Total	0.979	0.006	691	702	1.028	0.6	0.968	0.990
Rural	0.985	0.005	561	572	1.031	0.5	0.975	0.995
Urban	0.954	0.018	130	130	0.978	1.9	0.919	0.990
Received 3+ Antenatal Check up (last live/still births of past 3 years)								
Total	0.965	0.007	691	702	0.998	0.7	0.951	0.979
Rural	0.971	0.007	561	572	0.981	0.7	0.957	0.985
Urban	0.940	0.021	130	130	0.969	2.2	0.899	0.980
Institutional Delivery (last live/still births of past 3 years)								
Total	0.748	0.032	691	701	3.747	4.3	0.685	0.811
Rural	0.707	0.038	561	572	3.915	5.4	0.632	0.781
Urban	0.930	0.023	130	129	1.005	2.4	0.885	0.974
Safe Delivery (last live/still births of past 3 years)								
Total	0.769	0.032	691	701	4.100	4.1	0.831	3.891
Rural	0.729	0.038	561	572	5.200	5.2	0.803	4.035
Urban	0.945	0.020	130	129	2.200	2.2	0.985	1.016
Received BCG Vaccination (last and last but one living children, age 12-23 months)								
Total	0.988	0.008	207	192	1.147	0.8	0.972	1.004
Rural	0.985	0.010	166	151	1.177	1.1	0.964	1.005
Urban	1.000	0.000	41	41	0.000	0.0	1.000	1.000
Received Measles Vaccination (last and last but one living children, age 12-23 months)								
Total	0.870	0.028	207	192	1.403	3.2	0.816	0.925
Rural	0.894	0.029	166	151	1.512	3.3	0.836	0.952
Urban	0.782	0.065	41	41	0.998	8.3	0.650	0.914
Birth order 3+ (births in last three years)								
Total	0.171	0.023	619	594	13.4	13.4	0.216	2.292
Rural	0.176	0.028	496	471	15.8	15.8	0.230	2.592
Urban	0.153	0.032	123	123	21.2	21.2	0.217	1.043

APPENDIX A

Sampling Errors Estimation

The accuracy of programme indicators such as contraceptive prevalence rate, unmet need, institutional delivery, antenatal coverage, etc. estimated from DLHS-RCH can be assessed in terms of stability of the estimated indicators as measured by the standard errors. Standard errors reflect only the appropriateness and suitability of sampling design adopted for RCH survey. However, the accuracy of estimated programme indicator is also affected to a great extent by non-sampling errors arising from lack of proper operationalisation and non-response cases, and are inherent in large scale surveys. The estimation procedure of District Level Reproductive & Child Health survey takes into consideration design appropriateness and non-response rates. DLHS-RCH estimator of a programme indicator is derived as

$$r = \frac{\sum_h \sum_j \sum_i w_{hji} y_{hji}}{\sum_h \sum_j \sum_i w_{hji} x_{hji}} = \frac{y}{x} \dots\dots\dots (1)$$

where the cell (h, j, i) stands for ith observational unit in jth primary sampling unit (PSU) in hth stratum, basically rural-urban areas of a district are taken as strata. W_{hij} is the sampling weight of (h, j, i)th cell inflated by response rates. The variables y and x denote the main and the auxiliary characteristics required for computation of proportion or ratio.

The equation for estimation of variance of programme indicator (r) is obtained after Taylor series linearisation as

$$\text{var} (r) = \frac{1}{x^2} [\text{var} (y) + r^2 \text{var} (x) - 2 r \text{cov} (y, x)] \dots\dots\dots (2)$$

$$\text{var} (y) = \sum_h \frac{n_h}{n_h - 1} [\sum_j \sum_i (w_{hji} y_{hji})^2 - \frac{\left(\sum_j \sum_i w_{hji} y_{hji} \right)^2}{n_h}] \dots\dots\dots (3)$$

$$\text{cov} (y , x) = \sum_h \frac{n_h}{n_h - 1} [\sum_j \sum_i w_{hji}^2 y_{hji} x_{hji} - \frac{(\sum_j \sum_i w_{hji} y_{hji})(\sum_j \sum_i w_{hji} x_{hji})}{n_h}] \dots\dots\dots (4)$$

and n_h is the number of sampled PSUs representing rural or urban areas of a district/state.

List of Selected Programme Variables for Sampling Errors, DLHS-RCH, 2002-04

Variable	Estimate	Base Population
CPR (Any Method)	Proportion	Currently married women age 15-44 years
Unmet Need	Proportion	Currently married women age 15-44 years
Any ANC	Proportion	Last live/still births of the past three years
ANC3+	Proportion	Last live/still births of the past three years
Institutional Delivery	Proportion	Last live/still births of the past three years
Safe Delivery	Proportion	Last live/still births of the past three years
BCG	Proportion	Children age 12-23 months
Measles	Proportion	Children age 12-23 months
BO3+	Proportion	Currently married women age 15-44 years with births in last three years

APPENDIX B

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APPENDIX C

Questionnaires

**Household Questionnaire
Woman's Questionnaire
Husband's Questionnaire
Village Questionnaire**

NOTES